# STATE TITLE V BLOCK GRANT NARRATIVE
# STATE: SC
# APPLICATION YEAR: 2006

# I. GENERAL REQUIREMENTS

## A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

## B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

## C. ASSURANCES AND CERTIFICATIONS

The signed Assurances and Certifications forms are kept in the official grant file.

## D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

## E. PUBLIC INPUT

Public input was requested through the MCH Bureau website with a request to review the current grant and submit comments electronically by June 15. The website includes brief instructions on how to review the current state (FFY'05) MCH Block Grant via a link to the MCHB National web site. No comments were received.

## II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

## III. STATE OVERVIEW

### A. OVERVIEW

Many economic, health, education and behavioral indicators remain frustratingly low for SC, a small and poor state with many of the problems associated with low socio-economic status. Poverty is a major threat to children in SC. Based on the 2000 census, 43% of children live below 200% of poverty compared to 33.5% of adults. Almost a third of the children in the state live in single parent family households. In 2000, 66.1% of mothers with children under 6 and 73.1% with children 6 - 17 were in the labor force. The scores of SC students rank among the worst in the nation on standardized education tests. Although SC ranks well in some indicators measuring economic growth and development, sharp disparities between whites and minority races and populations are evident. Employment may be readily available in areas where tourism is a major industry, but the jobs filled by minorities are more likely to be low wage and not offer health insurance benefits. Unemployment rates are higher for minorities, especially in rural counties and in areas without a diversified industrial base.

SC scores very poorly on many indicators of maternal and child health status. The rate of very low birth weight, early prematurity, and infant mortality of black and other mothers are all over two times those of whites. The larger racial disparities persist at comparable levels of maternal age, education, income and marital status. The gap between black (and other races) and white populations for many health indicators is not improving.

2002 data revealed that 56.7% of all female head of households have incomes below 200% of poverty, 44.8% for white, 67.7% for black and 69.7% for Hispanic households respectively. Twenty-one percent, or about 1/5 of women delivering a live birth in SC in 2002 had not completed high school. Almost half (47.5%) of all births in 2002 resulted from pregnancies that were unintended, far above the Healthy People 2010 goal of 30. The births to teens rate (15-17 years old) continues to decrease, 28.1 in 2004 verses 28.8 in 2003.

The state is far below the Healthy People 2010 goals of 90% for first trimester entry into prenatal care and 90% of women receiving adequate prenatal care. In SC, the number of women beginning prenatal care in the first trimester has shown a continuing decline since 2000, 78.6% in 2000, 78.5% in 2001, 77.7% in 2002, 76.2% in 2003, and 67.4% in 2004. The gap between black and white women entering into prenatal care has continued but seems to be closing. The percentages of white and black women who entered prenatal care early decreased slightly last year for both races, 80% in 2003 verses 82.0% in 2002 for white women and 69% in 2003 verses 69.6% in 2002. In 2003, a small decrease was seen in the percent of pregnant women who received adequate prenatal care (Kotelchuck index), however, there is still a racial gap, 73.1% for all women, 75.7% for white and 68.4% for black women.

The number and percentage of births whose mothers were of Hispanic origin continues to increase dramatically since 1997. In 1997, the number of Hispanic births was 1,147 or 2.2% verses 3,188 or 5.85% in 2002, and 3,671 or 6.6% in 2003.

The state infant mortality rate dropped nearly 11% between 2002 and 2003. The 2003 infant mortality rate of 8.3 deaths per 1,000 live births represents a 10.8% decrease from last year's rate of 9.3. This significant decrease is due in large part to a 15.6% decrease in infant deaths in the black and other category, which is down from 15.4% per 1,000 live births the

SC's percentage of births less than 37 weeks gestation has been increasing since 1998, 10.6 in 1998, 11.2 in 2000, and 12 in 2003. Secondly, the percentage of low birth weight babies (<2,500 grams) is not declining, but has actually shown increases in the past 2 years, 10.1 in 2003, verses 10 in 2002, and 9.6 in 2001. The percent of black babies with a low birth weight (14.6) continued for the second year to be almost twice that of whites (7.6) in 2003. Nationally, black mothers in every age category -- not just teens-have a greater risk of losing their babies than white mothers of similar age. According to the 2005 SC Kids Count report, the cost of hospitalization for each low birth-weight baby in the state in 2001 - 2003 was $16,544 and $94,378 for each very low birth-weight baby, compared with $2,109

for a baby of normal birth-weight. The result was excess costs in the state of $163,607,316 for all low birth-weight babies, of which $100,481,910 was for very low birth-weight babies, and $63,125,406 for intermediate low birth weight babies.

Major providers of health care services for maternal and child populations in SC include physicians and dentists in private practice, for-profit and not-for-profit hospitals, federal health clinics, state public health agencies, and county health departments. In addition to these components of the service delivery system, numerous foundations, professional organizations, and universities focus on promoting maternal and child health through research, educational campaigns and materials, development of practice standards, and legislative advocacy. Some linkages exist between parts of this system of care, i.e., hospital transportation and back-transport for very low birth weight deliveries; statewide immunization information system for county health departments; medical home service coordination through health departments and private medical providers; and coordination of early intervention services through BabyNet (Part C). However, routine coordination between components of the overall system is not in place.

The role of the Department of Health and Environmental Control (DHEC-state and county health agency) at state, district and county health department levels is moving toward more involvement in building, supporting and facilitating community health care systems through core public health assessment, assurance and policy development functions. More communities are looking at health care systems in a comprehensive manner and community assessment initiatives are active in over half of the counties in the state. DHEC districts are encouraged to provide and support leadership in county and community coalitions, develop public and private partnerships, strengthen infrastructure building, and transition staff to provide more family support services. The role of DHEC is changing from being a primary provider of medical services to indigent clients, to coordinating private/public partnerships and providing wrap-around family support services (public health nursing, health education, nutrition, social work and paraprofessional services) to complement the medical services provided by other partners. Numerous pediatric partnerships for medical homes, obstetric partnerships for prenatal care, agreements with dentists for referrals, partnerships with schools for nurse placement, and community coalition partnerships, e.g., First Steps to School Readiness, are in place. Partnerships with dental providers to provide Medicaid funded dental services in school-based programs have been a successful addition in the past two years.

Access to comprehensive, high-quality health care services is a continuing health care delivery system problem. Long-term barriers that decrease availability of services and access for low-income families of all races include:
-Insufficient number of physicians and dentists enrolled in the Medicaid program and providing services to low income families.
-Lack of health care providers in rural areas.
-Low Medicaid reimbursement rates for physicians providing prenatal care and child care, especially for subspecialty physicians caring for children with special health care needs.
-Disproportionate distribution of Medicaid patients to physicians in many locations.
-Disproportionate distribution of Medicaid patients to dentists in many locations.
-Number of children and youth not enrolled in Medicaid, although eligible for enrollment.
-Growing number of permanent Hispanic residents without legal status, who are therefore not eligible for Medicaid enrollment.
-Growing number of working poor families that have too much income for Medicaid eligibility but receive no health insurance through their employer.
-Intense and persistent pressure from some hospitals to weaken the state's perinatal regionalization system.
-Insufficient or inadequate transportation for patients and families.
-Disparity of utilization of health care services by minority groups. Functionally illiterate young families may not access programs designed to benefit them because paperwork and processes are too complex.

Medicaid continues to be a major payer for deliveries. However the percentage paid for by Medicaid

has dropped slightly to 49.4 in 2003 from 49.5 in 2002 percent of all deliveries according to the Prenatal Risk Assessment Monitoring System (PRAMS). The percentage of deliveries paid by Medicaid differs by race, 75.9% for blacks verses 36.8 for white, and 42.1% for other races. Factors that may have contributed to this drop may be due to the fact that there have been changes in the Medicaid eligibility and outreach process. With recent budget constraints, the Medicaid eligibility process has been compromised. There are fewer out-stationed workers in provider areas, especially in local health departments and the agency has developed a very cumbersome application process. Although the application can be mailed in, it is so complex that many clients are not able to complete the application. In 2002, the EPSDT administrative outreach contract that DHEC had with DHHS was cancelled. Therefore, while evaluation data regarding children whose care is provided in public/private partnerships demonstrates improved utilization in partnership practices, the Medicaid overall data system has been changed and evaluating the relationship between screenings by provider by county is no longer available. Additionally, screenings provided in the managed care arena are only partially captured.

Increased Medicaid reimbursement for dental services in 2000 provided an incentive for more dentists to enroll as providers in the Medicaid program, resulting in increased numbers of children receiving dental health services. Over 1000 dentists are now enrolled as Medicaid providers (over 50 percent of all dentists in the state), compared with less than 600 in 1999. Program modifications in December 2001 identified and maintained improved funding for medically necessary pediatric dental services. These program changes have continued the increase in the number of eligible children receiving a dental service while reducing program expenditures. The number of children receiving dental services continues to increase substantially.

Over the past five State Fiscal Years (2001-05), the Agency has experienced a cumulative state budget cut of 33.96% of state funds (2001-10%, 2002-6.5%, 2003-8.73%, 2004-8.73%, 2005-level). The Agency projects a decrease of $700,0000 for the next state budget year (2006).

These budget cuts have had an impact on the ability of the Agency and the Bureau to perform its responsibilities and provide services to clients. Positions have been held vacant requiring staff to take on additional duties without additional compensation and the workload has not diminished. Since 2000, Health Services has decreased from 4,102 to3, 355 full time positions, a loss of 747 positions or 18%; and decreased clinic sites by 15 or 14% going from 110 to 95 clinic sites statewide. These figures do not include the bioterrorism positions that Health Services has acquired during this period. The budget impact can also be seen below by the 22.2% decrease in the number of clients seen by MCH staff in 2004 verses 2000:

Number of Clients Served 2004 2003 2000

Pregnant Women 17,668 19,212 18,722
Infants 27,637 26,632 18,006
Children 122,911 116,748 208,695
Children with Special Health Care Needs 13,438 10,944 11,914
Others 107,451 116,748 114,044

Total 289,105 290,284 371,381

To assist with this budget and staffing decrease, the staff and leadership of the Agency and the Bureau have developed priorities and begun extensive reviews of existing programs, processes and staffing patterns in order to improve the efficiency and effectiveness of what, why, how and who of service provision and support the Agency and Health Services continues to provide.

The state Medicaid agency has also experienced difficult budget years over the past several years. However, during the past three legislative sessions (2003, 2004, and 2005), the Medicaid agency maintained their funding levels with no significant budget cuts and even received permanent funding instead of temporary funding in 2005. However with the increasing costs and demands for services, it

has implemented several actions to decrease expenditures. During 2004, the Medicaid Agency implemented co-pays (MCH services exempt), and an active client re-determination process. It has also developed a list of over thirty possible actions that could be implemented if expenses exceed revenues.

During 2005, the Medicaid Agency began a process to ensure that all services are consistent with the State Plan approved by CMS and to decrease expenditures. In July 2005, they determined that enhanced family planning educational services would no longer be allowed. Secondly, allowable Family Support Services will be decreased to services that are medically related. These two changes will result in fewer services to clients and a large decrease in Medicaid earned funds that are available to the Agency to support MCH services.

During the last year and in the next year, the Medicaid Agency will be aggressively pursuing and implementing several managed care options. During 2004, it planned to implement a Disease Management program for individuals suffering with asthma, hypertension and diabetes. This program was not implemented due to the lack of a successful vendor. The Medicaid Agency continues to look for ways to implement this program and has begun dialog with DHEC to investigate the possibility of DHEC developing a Disease Management program beginning with the ADA diabetes model replicated to other diseases in the future.

The Medicaid Agency is implementing managed care concepts for children through the implementation of pilot Primary Care Case Management (PCCM) programs in 4 areas of the state. DHEC is actively assessing capacity and ability for DHEC to be a partner in these pilot programs. DHEC has a contract with one of the vendors to develop the public health component of this new program and is discussing contracts with the other 3 vendors. The PCCM program is being designed to support the primary physician provider and the medical home concept. The MCH Bureau and the agency envision the PCCM model as an excellent opportunity to partner with primary care providers to provide complimentary services to clients, and moving MCH resources down the pyramid to improving systems of care for this vulnerable population as well as the total MCH population.

MCH Bureau
Title V provided invaluable guidance as well as funding during the changes and transition that occurred in South Carolina in the past few years. The MCH Pyramid of Health Services offers a concept and framework for building stronger health care delivery systems. The MCH Pyramid is included as an attached file. Title V funding is the foundation for maternal and child health programs in SC. Development of a web of inter-connecting health care delivery systems at county, regional and state levels to improve the health status of women, children, youth and families, including families with children and youth with special health care needs, is an ongoing, continuous process toward an ideal goal. Title V funding enabled the infrastructure building to take place for an MCH Pyramid of Health Services especially designed for this state.

The MCH Bureau provides a coordinated focus for the Public Health Services Deputy area and the agency for priority setting, planning, policy development, and administration of programs for maternal and child health populations. The Bureau works with Health Services management to establish priorities; assure consistency in messages affecting MCH populations, i.e., assessments, problem statements, planning, evaluations, service delivery, program implementation; assures integration of efforts across Health Services program areas; and enables creative thinking to improve health outcomes and achieve state and national objectives for all women, children, youth and adolescents.

Several policy and planning initiatives to examine health services for mothers, infants, children and youth are currently ongoing and provide an opportunity to build a more comprehensive health care service delivery system for all children and youth in the state. These initiatives include:
-Implementation of a single Health Services Operational Plan (HSOP) for all regions and central office divisions that is based on the agency's strategic plan and long term outcomes. All MCH Title V Block Grant performance measures are incorporated into the HSOP;
-Initiation of a Performance Management System for the Agency, with the MCH Bureau being a

leading entity
-Integrated Systems for Children with Special Health Care Needs grant to increase medical homes, partnerships, enhance the health care systems.
-Submitted request for Early Childhood Comprehensive System planning grant.
-Submitted request for child health improvement partnership grant through the National Initiative for Children's Healthcare Quality (NICHQ).
-Creation of the Children's Health Consortium to improve partnerships and systems of care for children.
-Implementation of the Closing the Gap Initiative on Infant Mortality grant
-Creation of a state Oral Health Advisory Council and a Children's Oral Health Coalition to implement the state Oral Health Plan and expand access and services.

In addition to the Title V block grant, other major funded programs within the Bureau include the Title X Family Planning Program and the CDC funded Childhood Lead Poisoning Prevention Program, both located in the Division of Women and Children's Services; BabyNet, the early intervention program for infants and toddlers, funded through P.L. 102-119 of IDEA, and located in the Division of Children with Special Health Care Needs; and the USDA funded Special Supplemental Food Program for Women, Infants and Children administered in the Division of WIC Services.

During the past several years, the Oral Health capacity of the state has increased dramatically through three new funding opportunities. More Smiling Faces in Beautiful Places is a Robert Wood Johnson Foundation funded oral health program targeting children form birth to six years as well as children and adolescents with special health care needs, and is dedicated to linking medical homes to dental homes through case management, education of medical and dental providers, education of the public, and empowering families to manage oral health. The state dental disease prevention program is a CDC funded program to strengthen the state's ability to conduct oral health surveillance, expand school-based and school-linked dental sealant programs, and expand community water fluoridation. The HRSA Systems Development grant currently funds community based public education and oral health improvement programs. The HRSA SOHCS grant supports community based initiatives to convene partners and create plans to address oral health needs of Head Start students.

## B. AGENCY CAPACITY

DHEC is the primary advisor to the state in matters pertaining to public health. It has the authority to make and enforce rules and regulations for the protection of public health and the environment. The rules and regulations enacted by DHEC have the force of law and affect many aspects of the daily life of citizens. A broad range of health and environmental responsibilities are specifically assigned to DHEC by law. Central operations of DHEC are located in Columbia, the state capitol of SC.

Statutory Authority:
The SC General Assembly established the State Board of Health in 1878. The SC Department of Health and Environmental Control (DHEC) was formed in 1973, when the Board of Health was merged with the Pollution Control Authority. Statutory authority for the department is primarily provided in Titles 44 and 48 of the SC Code, 1976. The department operates under the supervision of a seven member Board of Health and Environmental Control, one member from each congressional district and one at-large member. The Governor with advice and consent of the Senate appoints board members. The chairman of the board is the at-large member and serves at the pleasure of the governor. The commissioner is hired by and serves at the pleasure of the board. DHEC is managed through five major organizational areas, each headed by a deputy commissioner: 1) Environmental Quality Control, 2) Health Services, 3) Ocean and Coastal Resources, 4) Health Regulations and 5) Administration. State level responsibilities for Title V rests within the Health Services Deputy Commissioner area.

Legislative and Congressional Statues:
In addition to the responsibilities mandated by the State, the Department performs a wide range of activities under Federal authority, in accordance with Federal laws and regulations. Among the programs operated under Federal and State authority are chronic disease, communicable disease, maternal and child health, family planning, health education and risk reduction, environmental sanitation, air quality control, radiological health, hazardous wastes, water pollution control, water supply, emergency medical services, bioterrorism and disaster preparedness, home health, personal care services and primary care. The legislative and congressional statutes providing authority for MCH programs follows:
A. Title V (Federal) Social Security Act: To provide for (1) health services for mothers and children to reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, (2) rehabilitative services for blind and disabled children under the age of 16, and (3) treatment and care of crippled children.
B. Title X (Federal) Public Health Service Act (Family Planning): To make comprehensive, voluntary family planning services readily available to all persons desiring such services.
C. Section 44-37-30, S.C. Code of Laws, As Amended, (Newborn Screening): Regulations for screening of metabolic disorders in infants. 2004 regulations resulted in improved standards and terminology to be consistent with national and medical standards and expansion of the test panel to nationally recommended list of 30 tests. D. Section 17 (Federal) (Child Nutrition Act - WIC): Provide supplemental foods, breastfeeding promotion and nutrition education to pregnant, postpartum and breastfeeding women, infants and young children.
E. Section 44-33-10, S.C. Code of Laws, As Amended, Section 39.7, Appropriations Act (1989-90): Provide education, voluntary screening, genetic counseling and referral services to children and adults with Sickle Cell disease, Cystic Fibrosis and Hemophilia.
F. Public Law 105-17, Part C, Individuals with Disabilities Education Act, State Law 114 (BabyNet): To develop and implement a statewide, comprehensive, coordinated, multi disciplinary, interagency program of early intervention services for infants and toddlers with developmental delay and their families.
G. Public Law 89-97, Formerly Social Security Act, (Federal) Title XIX, (EPSDT): Preventive (well) health services to Medicaid eligible children from birth to age 21.
H. Childhood Lead Poisoning prevention and Control Act (State) (Lead Screening and Follow-up): 2005 amendment renamed and clarified article to be related to children. DHEC has had the mandate to establish a program for early diagnosis of cases of lead poisoning and identification and reduction of sources of lead. Screenings are conducted by providers as a component of EPSDT services.
I. Preventive Dental Services (State): Section 40-15-110, SC Code of Laws, As amended, grants the Department the ability to target preventive dental services in a public health setting to under-served populations using the services of dental hygienists performing under general supervision without a prior patient exam by a licensed dentist. This legislation also defined the service dental assistants may perform through the Department.
J. Birth Defects Act (State): Legislation was adopted that establishes a birth defects program within SC DHEC. An active system for monitoring will be developed and include surveillance from prenatals through age two. No funding was provided to establish the program and the implementation is contingent upon the availability of funding. This program will be developed within the Division of Perinatal Systems.
K. Fetal Death Certificates (State): Requires SC DHEC to issue fetal death certificates for deliveries resulting in a live still birth for births of 20 completed weeks or more or a weight of 350 grams or more.
L. Section 44-37-40, SC Code of Laws, As amended, "Universal Newborn Hearing Screening and Intervention Act", Provisions requiring newborn hearing screening, establishing evaluation and intervention procedures, services and reporting procedures for hospitals, audiologists and early interventionists for monitoring and measurement of effectiveness.

2005 Health care legislative issues passed:
-Primary seat belt enforcement
-Requirement that each school district adopt a policy that children with special health care needs have an individual health care plan and are allowed to self-administer their own medication, if the child's doctor agrees.

-Changes to the retirement system for state employees
-Reciprocal licensing with other states for practicing nursing
-Reciprocal licensing with other states for practicing dentistry
-Alternate process for enacting a health care power of attorney
-Transfer of prescriptions and refills by pharmacists
-Establishment of standards for minimum physical education, health services, and nutrition for elementary grades
-Clarification of attendant care services and health maintenance activities from nursing
-Stronger domestic violent offenders law
-Childhood Lead Poisoning Prevention and Control Act
-Licensure by credentials for dentists.

2005 Health care legislative issues discussed but not passed:
-Youth Access to Tobacco Prevention Act
-Moving childcare from Department of Social Services to Health and Human Services Agency (Medicaid)
-Equalized Education Finance Act
-Immunization Registry Act (an electronic repository of vaccination records to be used in aiding childhood disease prevention and control)
-Putting Parents in Charge Act -Tax credits for sending children to private school
-Restructuring State Health Agencies including the transfer of the Early Intervention Program (BabyNet) from DHEC to DDSN.
-Healthy South Carolinians 2010 Act, which will target disparity health issues in SC
-SC Medicaid Accountability Act, which review all Medicaid spending and re-vamp the way Medicaid clients receive their services.
-Cigarette tobacco tax, increasing the amount of taxes per tobacco item

Title V Capacity:
Title V capacity in South Carolina has been adversely affected by the state budget cuts over the past five years, the changing environment of Medicaid services, and the additional demands of bioterrorism and emergency preparedness. However, MCH staff continue to provide services, prioritize initiatives, and search for efficiencies that can maximize and target resources. Following are descriptions of MCH programs and services in SC paid for in part or whole by Title V, or programs that through their participation on MCH issues are increasing their coordination with the MCH Bureau and vice-versa. Where eligibility requires payment for services, the Family Planning sliding fee scale provided in the FY 1996 application is still in use.

Women and Children's Services Division
The Women and Children's Services Division is organized into six general areas to allow for the best utilization of expert staff and to increase efficiency. All activities are targeted toward improving access to risk appropriate care for pregnant women, infants and children and low-income women seeking family planning services. These programs function with the support of an administrative staff and utilization of a multi disciplinary team of consultants (Health Education, Nursing, Nutrition, and Social Work).

1) Family Planning: Services are provided statewide according to the regulations and guidelines of Title X of the U.S. Public Health Service Act and include the following: physical examination, contraceptive of choice with counseling, and other services. SC has a Family Planning waiver in place, which extends eligibility for services to include coverage for all women up to 185% of poverty regardless of their childbearing status. Family Planning outreach efforts are fully operational and ongoing outreach is provided to teens and patients whose prenatal care was provided in either the public or private sector.
2) Infant, Child and School Health Services:
a) Postpartum/Newborn Home Visits: All infants who are on Medicaid are eligible for a postpartum

newborn home visit. During the visit, the mother and infant's health status are evaluated. Infants receive a thorough physical appraisal, weight check, and are enrolled in WIC. The nurse also ensures that the infant's two-week check up is scheduled with the primary care provider. Mothers are encouraged to have a primary care provider and to maintain routine well care and immunizations for the infant. Health education and referral to community resources are provided as needed. The physical environment is assessed to determine if problems exist that would be detrimental to the health of the infant. A follow-up visit or referral for FSS is made if the assessment indicates a need. DHEC continues to maintain a long-range goal of making this visit available to all newborns in the state.

b) School Health: An innovative school health partnership between the State Medicaid agency, the State Department of Education (SDE) and DHEC to designate school districts as Title V providers was implemented in September, 2003. In 2005, 55 of 85 school districts participated. The Title V designation allows school nurses to bill for services provided to Medicaid children, not just to Medicaid children with Individual Education Plans. An annual school nurse conference and orientation for new nurses were held. WCS also employs an MSW who is partly funded by the Department of Education and who provides support training and partnerships to increase the number of social workers in schools.

c) Well Child Health Services: These services are provided to fewer and fewer Medicaid and non-Medicaid children who still use the Health Department as their primary care provider. These children receive limited or comprehensive services depending on need. Medicaid children are provided services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and non-Medicaid children receive the same services through well child clinics. All children are risk assessed for the presence of a medical home, as well as educational, nutritional and psychosocial needs. When needs are identified, they are referred to Family Support Services (FSS) for follow-up

3) Early Childhood: Coordinating health efforts with our state's early childhood initiative, "First Steps", to ensure that children are healthy and ready to learn at school entry is the focus of this area. A comprehensive systems planning grant was submitted in April 2005 to assist in improving these systems for very young children.

4) Systems Development and Medical Home Partnerships

To accomplish the MCH goals for women and children there is continued focus on the development of private/public partnerships in which local physician practices provide the medical care and the health department provides preventive and supportive, core public health enabling services based on the unique needs of the local community. Although the maintenance and expansion of partnerships is a bureau priority, statewide staff losses have made this priority a challenge. In 2000 we had reported over 100 partnerships but in 2005 we had less than 50 formal partnerships across the state. In the next fiscal year and with ongoing negotiations with Medicaid, we are hoping to assist districts in providing a more targeted approach to serving clients in partnerships.

a) Primary Care Case Management (PCCM) partnerships

PCCM is one of the Medicaid agency's managed care options for children that is being piloted in 4 areas of the state to date. DHEC anticipates that this approach will continue to spread through out the state in the next two years. DHEC has a contract with one of the vendors to develop the public health component of this new program and is discussing contracts with the other 3 vendors. The PCCM program is being designed to support the primary physician provider and the medical home concept.

b) Integrated Community Health Systems for Children: A grant to improve health care systems for children, including children with special health care needs, was recently awarded to the state. Strong medical home partnerships and the accompanying support systems are both components of this grant.

c) Family Support Services (FSS): Services provided to mothers and children in SC have been enhanced through the implementation of a Medicaid contract to provide risk appropriate Family Support Services to all Medicaid eligible populations. FSS may be provided in the clinic, home, school, or day care setting. Services have been recently reviewed and redefined by the Medicaid agency to ensure that they are in compliance with the Medicaid State Plan. Services must now be medically necessary. This redefinition will decrease the number of and types of services provided by DHEC such as those services that were primary prevention and psychosocial in nature. These services are key to the ongoing promotion and viability of private public partnerships. Providing these core traditional supportive services enhance the ability of the primary care providers to serve as

medical and dental homes for families in the state.
5) Infant and Child Screening Services
a) Newborn Screening: Women and Children's Services maintains a statewide registry of infants identified with one of the newborn screening conditions; monitors laboratory tests; and reports results to providers with recommendations for follow-up. Local health departments and Children's Rehabilitative Services (CRS) clinics provide linkages to specialty medical care, and distribute special formula for patients with PKU and other inborn errors of metabolism. During the fall of 2004, the state expanded the test panel to include screening for cystic fibrosis, biotinidase deficiency and additional disorders of fatty acid, amino acid and organic acid metabolism. The expansion required the implementation of a new data system for newborn screening. This new system will soon allow infant newborn screening results to be linked with the electronic birth certificate.
b) Lead Screening: The central office maintains a statewide registry of cases of child lead poisoning, and monitors and classifies all test results analyzed in DHEC and private laboratories. Other services include coordination of follow-up testing and educational interventions, contractual arrangements with the Bureau of Environmental Health for environmental investigation for sources of lead, and provision of specialty medical consultation for private providers. As of January 1, 2004, blood lead screening responsibility was transferred to the EPSDT provider. Local health departments provide testing and follow-up services to approximately 160 children ages 1-6 years of age annually. Environmental investigations and technical assistance regarding abatement procedures is also provided for cases of lead poisoning with levels high enough to meet established protocol.
6) Administrative and Data: These staff provide the administrative and data functions for the Division.

Division of Children with Special Health Care Needs:
Most MCH Bureau programs and services for children with chronic illnesses, disabling conditions and/or developmental delays are housed in the Division of CSHCN. Key programs and services are listed below:

1) Children's Rehabilitative Services. The goal of CRS is to provide multidisciplinary rehabilitative and early intervention services to help assure that children with special needs are able to achieve their optimal level of functioning at home, school and in the community. Over 10,000 children (0-21) whose family income is less than 250 percent of poverty receive direct care or other program services. Eligible children must be diagnosed with covered conditions that include, (but are not limited to): diseases of the bones and joints; congenital anomalies; cardiac defects; rheumatic fever; hearing disorders; epilepsy/seizure disorders; hemophilia; cleft lip/palate; other craniofacial anomalies; cerebral palsy; residuals of trauma; sickle cell disease, and other central nervous system disorders. Program services include: primary and medical subspecialty care in private facilities, through DHEC operated clinics, or through public/private partnerships; medical equipment and supplies, pharmaceuticals; metabolic and special formulas; audiology and special therapies; care coordination; psycho-social support and education; and hospitalization. Physicians, dentists, nurses, social workers, nutritionists, health educators and parents provide these services.
2) Supplemental Security Income: Division staff assure referral of SSI-eligible children to facilitate receipt of appropriate medical, educational, developmental, rehabilitative, counseling and social services through coordination with other state agencies.
3) Hemophilia Assistance Program: Purchase of blood products and supplies for children and adults with congenital blood coagulation disorders when income is at or below 250 percent of federal poverty level.
4) Adult Sickle Cell Disease: On-going support for children and adults with sickle cell disease through four community-based non-profit organizations in this state.
5) Genetic Disease Testing and Counseling: Support for genetic disease testing and counseling services through the State's three regional genetic centers. Title V resources are earmarked for children and families with incomes less than 150% of the federal poverty level.
6) Parent Support Services: Parent support services in each of the State's public health districts (now regions) are planned and coordinated by Parent Resource Specialists responsible for providing or arranging parent support services for parents and caretakers of children served through county health departments and medical home service sites. These parents serve on the Division's Parent and

Consumer Advisory Council (PCAC). Recent PCAC activities and initiatives include development of a: Personal History Folder; Family Information Packets; parent satisfaction surveys and a parent newsletter called "Children Are Special" and the medical home training. Council members are active at the state and local level in addition to providing support to state committees addressing SSI, transition, policy, and health care reform issues for CSHCN.
7) Transition Coordination: Division staff includes a transition coordinator responsible for working across agencies to effectively develop systems for facilitating transitions between service systems (i.e. Part C to pre-school), from pediatric to adult/self care, and from school or work or college. Through a signed Memorandum of Agreement with S.C. Vocational Rehabilitation, cross training of service staff, coordinated care and provision of collaborative services and treatment plans are conducted, where appropriate.
8) Camp Burnt Gin: DHEC has operated a camp for children with physical disabilities with state and Title V funds since 1945. Camp Burnt Gin has developed special camping experiences and curricula for adolescents, young adults, HIV positive children, and children served by the Muscular Dystrophy Association. In addition, the camp director camp director works with camps throughout the state to promote inclusion.
9) Newborn Hearing:
10) Early Intervention services (Part C of IDEA): DHEC serves as the lead agency for the State's IDEA Part C early intervention program (BabyNet). Staff responsible for assuring completion of these tasks are located in the Division.

Planning for all children, including those with special health care needs has been fully integrated into the DHEC operational plan. During the annual planning process across MCH services, regions are asked to report the number and type of specialty clinics being offered each month to assure that adequate access to specialty care is available at the local level. Regions are also asked to describe their discharge planning activities to assure linkages back to community systems and to describe all partnership initiatives.
The Division is coping with significant staff turnover during the past 12-18 months. Changes include retirement of the long-time Division Director and Assistant Director and other senior staff members. While this has produced a very stressful work environment for several months, plans are in place to fill key positions and to fully assess organization and functions within the Division.

Division of Perinatal Systems
This Division serves as the focal point for various perinatal health issues in the state including:
1) Perinatal Regional Systems Development: The Agency provides resources to strengthen the Perinatal Regionalization System, including tertiary care centers to impact infant mortality. There are five regional perinatal centers located within four regions. The system includes designation and licensing of level of hospital care as either Level I (basic), Level II (specialty), Level IIE (enhanced care) or Level III (sub-specialty). To support perinatal systems development, each perinatal region has a Regional Systems Developer and Obstetrical and Neonatal Outreach Educators who work with all providers and hospitals within the region. DHEC has facilitated the development of written Memoranda of Agreement between the Regional Perinatal Centers and referring hospitals. Activities also include the collection, analysis and dissemination of perinatal data.
2) 1-800-868-0404 SC's Maternal and Child Health Hotline: The CARE LINE is a toll-free statewide phone line which provides assistance and support in gaining access to prenatal care, infant and child health care, assessment and care for children with special needs, family planning services and other related services to SC women, their significant others, and service providers. The CARE Line's goal is to improve access and enhance health by identifying and resolving barriers to care. This resource was able to grow into a more comprehensive system through a partnership of MCH, WIC, March of Dimes, and the Caring for Tomorrow's Children program.
3) Fetal and Infant Mortality Review (FIMR): The fetal and infant mortality review is a community owned, action oriented process that studies fetal and infant deaths to learn how to improve community systems and increase resources to improve outcomes. Information obtained from FIMR can enhance the health and well being of women, infants, and families by identifying gaps in the local health systems and by addressing barriers that exist. In 2004, implementation of fetal and infant

reviews was identified by the Bureau as a priority activity for each health district. Program staff have developed a one-page review tool that each District will implement as a minimum. The tool looks specifically at the role of the health department with this population.
4) Women's Health Liaison: The Division Director serves as the state's women's health coordinator and liaison with the regional and federal Offices of Women's Health.
5) Sexual Assault Prevention and Treatment Program: This program provides technical support to central office and health district staff and customers (primarily adult and adolescent females). The program supports the SC Coalition Against Domestic Violence and Sexual Assault as well as 16 rape crisis centers throughout the state. These centers provide prevention and treatment services to survivors in all 46 counties of the state.
6) Caring For Tomorrow's Children Program: This program includes an information and education book for any pregnant women or parents with a child under the age of 1 and covers preconceptional health, the prenatal period and the infant's first year of life. Additionally, a video and poster on early development and learning is available to all parents with a child under the age of 3. A grant from the March of Dimes and an administrative contract with DHHS provided the financial resources for the program.
7) Prematurity Campaign: The Division has partnered with the SC March of Dimes to develop and implement the National MOD Prematurity Campaign. A Summit on Premature Birth was held in June 2005 with over 225 participants from across the state and representing public health, private providers, community groups and business leaders. The goals are to increase awareness of the problem and decrease the rate of premature birth.
8) Closing the Gap on Infant Mortality: African American Focused Risk Reduction Grant: SC is one of four states that received a grant to decrease the health disparities in low birth weight, prematurity, and infant mortality. The grant activities are occurring in the 3 counties (Georgetown, Horry, Williamsburg) of the state with the highest race disparity for infant mortality.
9) Birth Defects Surveillance and Prevention Program: The SC Birth Defects Act signed into law by the Governor in June, 2004 provides DHEC with the authority to conduct public health monitoring and prevention activities for birth defects. The limited surveillance activities that have been conducted by the Greenwood Genetics Center will be transitioned to DHEC as funding becomes available. A program coordinator has been hired and will develop policies and procedures and facilitate the transition of current surveillance activities to DHEC.

WIC

WIC is a targeted Special Supplemental Food Program established by Congress in 1972, and federally funded (USDA) through monetary grants to assist states (DHEC) in safeguarding the health and nutritional well being of our low income women, infants, and children during critical growth periods. The population served includes pregnant, postpartum, and breastfeeding women, infants, and children until age five. The SC WIC Program and the SC Department of Agriculture jointly sponsor the SC WIC Farmers Market Nutrition Program. In counties that have a viable and authorized farmers market, WIC Farmers Market coupons are provided on a one-time basis to women and children enrolled in WIC. Clients not only purchase fresh fruits and vegetables at the market, they also learn how to select, store and prepare fresh produce during WIC education classes.

Division of Oral Health

Since June 2000, the Oral Health Division of the MCH Bureau has coordinated the state's dental public health efforts. Multiple collaborations and existing public-private partnerships provide a framework for a grassroots approach to oral health issues. The Division has developed a strategic plan, statewide Advisory Council and a Coalition, developed an implementation plan for the social marketing plan to improve oral health literacy. Program coordinators have established a statewide oral health surveillance system, partnerships for pre-natal, early childhood and school-based dental prevention programs; community based oral health improvement and improvements in community water fluoridation. Dental providers in the Department's school-based programs provided preventive services to over 34,283 children in the 2003-4 school year. Local partnerships have been initiated in eight counties in order to integrate oral health activities into the local children's health systems by

linking the medical and dental homes, providing outreach through the faith and education communities and the local DHEC health district staff.

This seciton is continued in Attachment III B.

## C. ORGANIZATIONAL STRUCTURE

State level responsibilities for Title V rests within the Health Services Deputy Commissioner area. Since 2002, Health Services has been led by Dr. Lisa Waddell and is managed through six areas, two Assistant Deputy Commissioner areas of Public Health Services, and Regional and Professional Services; and 4 Directors of Health Services Administration, Minority Health, Performance & Information Management, and Clinical Services. Implementation and coordination of maternal and child health programs occurs within the Public Health Services area in conjunction with the Regional and Professional Services area, where the professional discipline offices for nutrition, social work and health education, and the six public health regions reside, the Clinical Services area where the nursing office resides. Financial monitoring of the Title V Block Grant is within Health Services Administration.

The Public Health Services Assistant Deputy Commissioner area now includes only four bureaus: 1) Maternal and Child Health, 2) Disease Control, 3) Chronic Disease Prevention and Home Health Services, and 4) Environmental Health. All the Bureaus serve maternal and child populations and the Bureau of Maternal and Child Health coordinates with other Bureaus on issues that are broader than a given Bureau area, i.e., HIV/STD (Disease Control); home visits and schools (Bureau of Community Health and Chronic Disease Prevention); lead poisoning (Environmental Health).

Included in the Appendix are two organizational charts that illustrate the general Agency, Health Services, and Bureau structures. The two charts are: 1) The structure of DHEC from the Governor down to the Bureau level within Health Services, 2) The structure of the MCH Bureau and its Divisions.

The Bureau of Maternal and Child Health (MCH) has primary responsibility and oversight of Title V programs in the state. Harvey Kayman, MD, MPH, was appointed Director in May 2005. Five divisions and one Unit are located within the Bureau. The Divisions are: 1) Women and Children's Services, 2) Children with Special Health Care Needs, 3) Women, Infants and Children (WIC) Services, 4) Perinatal Systems, and 5) Oral Health. The MCH Epidemiology Unit was recently recreated back within the MCH Bureau and is under the direction of the Assistant Bureau Director.

Key Leaders:
Following are brief biographies of key leaders within MCH in DHEC:

Harvey Kayman, MD, MPH: Director, Bureau of Maternal and Child Health. Dr. Kayaman was appointed as the Director May 2005. He has over 30 years experience in pediatrics, medical consultation, managed care, and public health. Most recently he served as the Bureau's Medical Consultant.

Candace Jones, MPH, RD: Assistant Bureau Director has been with the Bureau since March 2002. Her responsibilities include coordinating the Title V MCH Block and SSDI grants, and the epidemiology, data and information needs of the Bureau in the absence of an MCH Epidemiologist. Candace has over 30 years experience in public health at the county, regional, and state levels in several states, 11 of those in SC.

Sarah Cooper, RN, MN, CS: Director, Division of Women and Children's Services. Sarah Cooper has over 25 years of nursing and management experience with DHEC, with positions at county, district,

and state levels. She is the agency team leader for medical home partnerships and oversees the new Medicaid managed care product entitled ‘Primary Care Case Management (PCCM)' pilot program.

Cheryl Waller, BSN, MPH, Director, Division of Children with Special Health Care Needs. Ms. Waller just joined DHEC in April 2005 from North Carolina. She also has over 25 years of nursing and management experience at the state and federal levels.

Janet Sheridan, MA: Director, Family Planning Program. Janet Sheridan has been with DHEC over 20 years. She previously served as Division Administrator, returning to the Division of WCS in 2000 as Family Planning Director. She has a broad background in fiscal operations and contract development and auditing and holds the designation as a Certified Public Manager. Her MA is in Conflict Resolution, and she is called upon frequently to apply her skills both internally and externally.

Burnese Walker, MS, RD: Director, WIC Program. Burnese Walker has over 20 years experience working with WIC programs in two states (Georgia and South Carolina). She has also worked with School Food Services at the SC Department of Education.

Luanne Miles, MSW: Director, Division of Perinatal Services. Luanne Miles has worked with maternal and child health programs at DHEC for the past 10 years. Previously, she worked as a clinical social worker with children and families for 11 years in both private and public health agencies.

Other staff playing important roles in partnership with the MCH Bureau:

Sandra Jeter, LISW. Lead contact for youth suicide prevention and domestic violence, and serves as DHEC's representative on the CDCs Healthy Schools Infrastructure Grant. Sandra Jeter is located in the Bureau of Community Health and Chronic Disease Prevention.
Staff Resources and Leadership
A listing of FTE positions (not all are slotted FTEs) within Health Services central office that work with the MCH population is provided below:

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Managerial/administrative/budget: 34.32
Administrative Support: 18
Program Director/ Manager: 20.7
Nutritionists: 3
Social Workers: 7
Health Educator: 4
Nurses: 5.15
Data and Research Managers: 10.73

Total: 102.9, of which 11.32 are in Health Services Administration.

## D. OTHER MCH CAPACITY

Bureau of Community Health and Chronic Disease Prevention
This Bureau deals with a variety of chronic diseases and health risks that affect the citizens and communities within SC, in particularly women. Areas of primary prevention emphasis include:

Office of Healthy Schools
This Office serves as the focal point within DHEC's Health Services Deputy area for Coordinated

School Health and maintains a strong collaborative partnership with the State Department of Education (SDE), the MCH Bureau, as well as other bureau areas within Health Services. A collaborative approach that focuses on building capacity and infrastructure for CSH within SC DHEC, between the SDE, other state, regional and local agencies interested in the health and academic success of our children is used.

The Office promotes the Center's for Disease Control/Division of Adolescent and School Health's Coordinated School Health model that addresses risk behaviors in children and youth for academic success and health outcomes; and is framed around the interrelated components of health education; physical education; nutrition; guidance, psychological counseling, and social services; a healthy school environment; staff wellness; and family and community involvement. This approach is vital if we want to effectively improve the lives of children and reduce the prevalence of chronic disease and disability for the citizens of our state.

Division of Injury Prevention
The focus of this Division is to prevent and reduce the occurrence of injuries and disabilities that impact upon the quality of life of all citizens of SC. Coordination of DHEC Injury and Violence Prevention (IVP) activities and the development of partnerships with state and local agencies and organizations that are essential for achieving this mission are major activities carried out in the Division. Programs include: 1) Child Passenger Safety Program 2) Traumatic Brain Injury Surveillance (TBI) 3) Residential Fire Injury Prevention Program 4) State Child Fatality Advisory Committee. 5) Disabilities and Health Initiative 6) South Carolina Violent Death Reporting System (related to mothers).

Division of Cancer Prevention and Control
This Division is focused on comprehensive approaches to cancer prevention and control across the cancer continuum, from primary prevention to treatment. This broad approach involves actual conduct, facilitation, and application of research and evaluation to public health practice by way of screening programs, community-based and academic partnerships, and
The SC Breast and Cervical Cancer Early Detection Program/Best Chance Network (BCN) provides comprehensive screening and follow-up services at no-cost to eligible women (age 47-64, uninsured or have hospitalization coverage only, below 200% of federal poverty level) through contracts with over 200 private physicians, federally-funded community health care centers, hospitals, laboratories, and radiology centers to deliver these services. In addition, the SCDHEC maintains oversight of the overall program administration and management, quality assurance, case management, data management, surveillance. The BCN has initiated strategies to build infrastructure to support services to Hispanic & physically disabled women. As of 2005, the Comprehensive Cancer Program is an Implementation Program. The state cancer plan will guide implementation efforts for cancer prevention and control through the SC Cancer Alliance (SCCA). The SC Cancer Alliance (SCCA), staffed by the Division, is a registered non-profit organization, with 700 members to date, that addresses the burden of cancer in the state through five key sectors: Research, Prevention, Early Detection, Patient Care, and Advocacy/Policy. The Division staffs and coordinates the Cancer Control Advisory Committee, consisting of cancer experts, appointed by DHEC's Commissioner, that advises the DHEC Board and staff on professional and programmatic issues pertaining to cancer prevention, care, and surveillance. The rising treatment costs, coupled with level annual allocations, has irreversibly diluted the ability of the State Aid Program to address the needs of our citizens, resulting in the ending of this program. The Division also collaborates in a CDC-funded research project in partnership with the University of South Carolina Prevention Research Center. The Division staffs and coordinates the Cancer Control Advisory Committee, consisting of cancer experts, appointed by DHEC's Commissioner, that advises the DHEC Board and staff on professional and programmatic issues pertaining to cancer prevention, care, and surveillance. Division of Cardiovascular Health (CVH)
The Division of Cardiovascular Health's mission is to prevent and reduce heart disease and stroke in South Carolina through the development and promotion of policy and environmental changes. The division, in collaboration with its partners, is implementing a plan of action to address the challenges of this disease. The plan includes a variety of activities that support efforts to: (1) Promote healthy

behaviors among all South Carolinians to prevent or reduce cardiovascular diseases (CVD)-with a focus on reducing health disparities, (2) promote early detection, treatment and control of risk factors for CVD (high blood pressure, high cholesterol, obesity and diabetes) and the early detection of CVD and (3) promote early and aggressive treatment of CVD.

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Division of Diabetes Prevention and Control
Working collaboratively with partners to maintain a statewide structure to support diabetes prevention and control is the mission of this division. The primary goal of the division is to reduce health disparities among high-risk and disproportionately affected populations, i.e., African Americans, Hispanics, elderly, the underinsured and uninsured, etc. The division uses a three- (3) pronged approach to include:
1) Monitoring the burden of diabetes through a statewide surveillance system, providing ongoing epidemiological information and surveillance of medical costs, and determining the impact of diabetes and its complications. Noted issues are the increasing prevalence of diabetes in African American women and the increasing occurrence of Type 2 diabetes in children. DPCP staff are currently working on a pilot project with Family Planning clients at risk for metabolic syndrome in 2 counties to evaluate impact of support groups/information. Additionally diabetes educators in DHEC are developing relationships with schools to better support children with diabetes in the school environment. 2) Working to improve access to quality care in office-based practices in medically underserved areas- The DPCP has Memorandum of Agreements with 11 of the 19 Community Health Centers across the state that are in the federally funded Diabetes Collaborative. In addition, DHEC Diabetes educators provide diabetes education to women with gestational diabetes as well as all Type 1 and Type 2 referrals from healthcare providers. DHEC now has an ADA recognized diabetes self-management program in ten sites across South Carolina. This program focuses on the clinical outcome of the A1c and individual behavioral changes.
3) Mobilizing communities through coalition building and programs such as Diabetes Today and Diabetes101 to strengthen their ability to promote awareness, decrease risk reduction behavior, and seek early detection. During the Diabetes 101 trainings, a survey to identify barriers to self-care will be completed by all participants. The plan is to analysis this community data to better define the needs of the community related to development of healthy lifestyles to prevent or manage diabetes.

Division of Obesity/Physical Activity and Nutrition
This division is charged with increasing state capacity to address obesity by establishing a statewide partnership comprised of public and private partners. The partnership will develop a comprehensive strategic plan to maximize resources, coordinate efforts, and evaluate efforts primarily focused on policy and environmental supports. Nutrition and Physical Activity State level consultants closely support these activities through staffing of various committee and work groups, (e.g., the SC Governor's Council on Physical Fitness), providing ongoing consultation and technical assistance to local health department staff, working with state-wide partners, and coordinating special programmatic efforts, such as: Walk to School events, the Governor's Conference on Physical Activity, and the " Five a Day" program.

Division of Tobacco Use Prevention and Control
The Division of Tobacco Prevention and Control in the Bureau of Community Health and Chronic

Disease Prevention focuses on reducing the incidence and prevalence of tobacco use among youth and adults through policy and environmental change, and providing resources to a network of community based coalitions and organizations. The Division reaches the MCH population through the following partnerships: The Tobacco Intervention and Prevention Strategy (TIPS) Program and the SC Tobacco Collaborative (SCTC). Activities include: 1) Active participation in the March of Dimes Program Services Committee advocating for the adoption of standard protocols for addressing tobacco use within medical practices that reach the MCH population; 2) Sponsorship of 5A's clinical intervention tobacco cessation training provided to OB-GYN providers by the SC Perinatal Association, DHEC Division of Perinatal Systems, and local health districts; 3) Collaboration with Palmetto Health District and the SC Cancer Alliance to deliver tobacco cessation clinical practice guideline training to medical practices, in particular those that provide healthcare services to women and children, and furnish provider reimbursement for trained clinicians. Additionally, the Tobacco Division and its partners have representation on the interagency Women and Children's Community Research and Practice Collaborative (WCCRPC) that focuses on reducing pre-term births in the state. The Tobacco Division also promotes the tools and resources of Smoke-Free Families and the National Partnership to Help Pregnant Smokers Quit, as well as the American Legacy Foundation's programs that target women who smoke. In particular, pregnant women who call the SC Smoking Cessation Quitline (877-44U-QUIT) are referred to the Legacy Foundation's Great Start smoking cessation resources. Two of the Tobacco Division's secondhand smoke initiatives include First Breaths, a program targeting new moms at post delivery with a toolkit to teach them the importance of and strategies for protecting them from exposure to secondhand smoke, and the Smoke-Free Homes Initiative, an effort developed by the Environmental Protection Agency (EPS) that encourages parents to sign a pledge to keep their homes and vehicles smoke-free.

This section is continued in the Attachment III D.

## E. STATE AGENCY COORDINATION

The Agency and the MCH Bureau in particular is moving toward developing systems of care and increasing partnerships and coordination efforts with other agencies, private providers, medical institutions, academic institutions, non-profit entities, and grantors as the health care environment evolves. The Medicaid agency is aggressively restructuring how it delivers and reimburses services to be more managed care and contractual in nature. Several different managed care models are being piloted or implemented via contract in which DHEC may or may not be included. In one instance, the Medicaid agency started in the fall of 2004 a new children's product entitled ‘Primary Care Case Management (PCCM)' in three upstate counties, Anderson, Oconee, and Pickens. The health departments in these counties and the central office are working within and with Medicaid staff to develop the public health role in this product. Currently, the counties have a draft contract to provide supportive services to clients served through this pilot.

The following represents a summary of the current Medicaid contracts, amendment contracts, and other Memoranda of Agreements between DHEC and DHHS.

1) Children's Rehabilitative Services. The goal of CRS is to provide multidisciplinary rehabilitative and early intervention services to help assure that children with special needs are able to achieve their optimal level of functioning at home, school and in the community. Over 10,000 children (0-21) whose family income is less than 250 percent of poverty receive direct care or other program services. Eligible children must be diagnosed with covered conditions that include, (but are not limited to): diseases of the bones and joints; congenital anomalies; cardiac defects; rheumatic fever; hearing disorders; epilepsy/seizure disorders; hemophilia; cleft lip/palate; other craniofacial anomalies; cerebral palsy; residuals of trauma; sickle cell disease, and other central nervous system disorders. Program services include: primary and medical subspecialty care in private facilities, through DHEC operated clinics, or through public/private partnerships; medical equipment and supplies,

pharmaceuticals; metabolic and special formulas; audiology and special therapies; care coordination; psycho-social support and education; and hospitalization. Physicians, dentists, nurses, social workers, nutritionists, health educators and parents provide these services.
2) Supplemental Security Income: Division staff assure referral of SSI-eligible children to facilitate receipt of appropriate medical, educational, developmental, rehabilitative, counseling and social services through coordination with other state agencies.
3) Hemophilia Assistance Program: Purchase of blood products and supplies for children and adults with congenital blood coagulation disorders when income is at or below 250 percent of federal poverty level.
4) Adult Sickle Cell Disease: On-going support for children and adults with sickle cell disease through four community-based non-profit organizations in this state.
5) Genetic Disease Testing and Counseling: Support for genetic disease testing and counseling services through the State's three regional genetic centers. Title V resources are earmarked for children and families with incomes less than 150% of the federal poverty level.
6) Parent Support Services: Parent support services in each of the State's public health districts (now regions) are planned and coordinated by Parent Resource Specialists responsible for providing or arranging parent support services for parents and caretakers of children served through county health departments and medical home service sites. These parents serve on the Division's Parent and Consumer Advisory Council (PCAC). Recent PCAC activities and initiatives include development of a: Personal History Folder; Family Information Packets; parent satisfaction surveys and a parent newsletter called "Children Are Special" and the medical home training. Council members are active at the state and local level in addition to providing support to state committees addressing SSI, transition, policy, and health care reform issues for CSHCN.
7) Transition Coordination: Division staff includes a transition coordinator responsible for working across agencies to effectively develop systems for facilitating transitions between service systems (i.e. Part C to pre-school), from pediatric to adult/self care, and from school or work or college. Through a signed Memorandum of Agreement with S.C. Vocational Rehabilitation, cross training of service staff, coordinated care and provision of collaborative services and treatment plans are conducted, where appropriate.
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Goal 1: To increase provision of Medical assistance to Medicaid eligible individuals and potential eligibles including reproductive aged women at or below 185 percent of poverty, infants at or below 185 percent of poverty, children at or below 150 percent of poverty and or children with special health care needs. For the last several years, the activities of this goal have been revised annually. Most recent changes for this goal are to move toward enhancing utilization of services by those children already on Medicaid and placing a priority on recruiting the Family Planning population.

Goal 2:To assist the Medicaid State Plan in recruiting providers to serve Medicaid recipients. This goal goes hand-in hand with DHEC's desire to promote public/private partnerships to assure medical homes for Medicaid recipients and includes the training of nurses in the private sector in the provision of EPSDT clinical services.

Goal 3:To improve birth outcomes for Medicaid eligible women and infants. The objectives of this goal are carried out through the regional perinatal contracts with the perinatal centers including referral and transport. In 2005, the Caring For Tomorrow's Children Program was added as a component of this goal.

Goal 4:To improve health outcomes of Medicaid eligible populations with special health care needs. Activities include the development of a coordinated tertiary hospital/local Medicaid health care service system that targets CSHCN. A second objective includes the development of a comprehensive implementation plan to establish a regional system of
care for Medicaid eligible individuals with Sickle Cell Disease.

2) Family Support Services (Across Bureaus): These services were developed in 1995 and extensively revised in 2005 in response to the desire to work in partnership with private providers to promote the medical home concept. This is a fee for service contract to provide Family Support Services to the existing Medicaid eligible population, including pregnant women, infants, children, and CSHCN. This contract gives all health districts the opportunity to provide risk assessments and provide services based on risks that are medically necessary or related. Services are also provided to assist families in the appropriate use of primary care and the practice of healthy behaviors. This allows DHEC to provide services to a greater population than is possible with the current population-specific contracts. Districts continue to provide FSS for all populations and for all programs. These services provide an excellent resource to our partnerships with
medical providers as they complement and enhance their provision of clinical services.

3) Clinical and Family Planning Services (Division of WCS): Contract which includes all clinical services for Maternity Care, Family Planning, Family Support Services and the Postpartum Newborn Home Visit.

4) Children's Rehabilitative, Clinical and Care Coordination Services (Division of CSHCN): Provides medical services to pediatric patients in the CRS or Children's Health clinics, nutrition, psychosocial services, care giver training, and coordination of services for special needs children through CRS and FSS. Occupational and physical therapy,
audiology and speech therapy services are also provided through CRS.

5) Purchase and Provision of Hearing Aids and Accessories (Division of CSHCN): Provides for the purchase and provision of hearing aids, hearing aid accessories and coordination of hearing aid repairs for Medicaid eligible children and recipients who are 21 years of age and over and who participate in the DDSN waiver program.

6) Administration and Provision of Orthodontic Services (Division of CSHCN): Provides for the provision and administration of orthodontia services to eligible individuals under the age of 21 who have qualified under the CRS program criteria.

7) MOA for Provision of State Matching funds for audiology, special therapies and Alpha-fetoprotein (AFP) testing (Division of CSHCN): Provides state matching funds for: physical therapy, occupational therapy, speech therapy, and audiology services to Medicaid eligible individuals served through the CRS and early intervention programs; and the increased reimbursement rate for AFP tests.

8) MOA for Provision of State Matching funds for persons with Sickle Cell Disease/Trait and Enhanced Genetic Services (Division of CSHCN): Provides state matching funds for family planning, genetic education and case management services to Medicaid eligible persons with sickle cell

disease/trait and enhanced genetic services
provided by genetic centers.

DHEC has been working in various ways to partner with the private medical sector in the provision of MCH health services. With the large indigent health service need, it is not possible for federally funded health centers, public hospitals, and the health department to meet all of the need. Based on this, previous Public Health Commissioners Mike Jarrett and Doug Bryant, worked to change the image of the health department from the provider of indigent medical services, to one of participant in a private/public partnership to complement with Family Support Services the medical services provided. To accomplish this change, the agency has had multiple interagency task forces (Obstetrical Task Force, Newborn-Infant Task Force, the State and Regional Perinatal Boards, and a Pediatric
Advisory group), met with state level provider groups, met with local medical groups and community groups, and based on input, modified service operations based on community need. The current DHEC Commissioner, Earl Hunter, chairs the OB Task Force and the Pediatric Advisory Committee, and the Director of DHHS has a Medical Care Advisory Committee where DHEC is represented. The agency currently has the following types of relationships with providers and hospitals: 1) contracting for physician services in the health department clinic and/or in their office to provide primary care; 2) contracting for hospital services; 3) contracting along with a hospital for another health agency to provide services; 4) as an access point to enter prenatal care by being screened and referred to the private sector; 5) out stationing of health department staff in provider's offices who provide case management services, nutrition, social work and health education services, after hours call, home visiting, preventive health services (immunizations, well child assessments such as EPSDT), outreach and anticipatory guidance, and; 6) other special arrangements, such as the medical home project for special needs children.

Key Resources/Groups Influencing the Provision of MCH Services
Multiple groups affect the provision of MCH Services. The DHEC Commissioner has promoted the building of partnerships between agencies and between private and public sectors as one of the most important initiatives to improve services. This attitude has spread among most groups and agencies providing health services statewide.

The Maternal, Infant, and Child Health (MICH) Council was established by the SC Legislature in 1986 to improve the health status of pregnant women, infants and children. This Council was disbanded in 2001 due to state fiscal constraints. The Council's work continues in small community workgroups and no longer provides a unified statewide
presence. Within the private sector, the SC Medical Association (SCMA), the SC Hospital Association (SCHA), the Alliance for SC's Children, Family Connections, as well as the Children's Hospital Collaborative have all been strong partners for promoting improvements in the provision of MCH services. The SC Dental Association and the SC Dental Hygiene Association have become strong partners in the past few years.

The Bureau of MCH, Health Services and all of DHEC, have consistently worked with related federal and state programs to coordinate services for mothers, infants and children. Coordination takes place in various ways, including: administration, planning and policy development, service provision, funding, and evaluation. Public Health levels of infrastructure include statewide, health district, county, service delivery site, and individual patients.

The Bureau of MCH and other Bureaus within Health Services have a strong working relationship with various state agencies. Efforts are underway to improve organizational structures, data systems, and client services through a number of efforts initiated through DHEC and these agencies. Several grant programs, such as SSDI, support an improved framework for service integration. Examples of the plans and activities are:

Community and Migrant Health Centers: DHEC works collaboratively with these centers to provide opportunities to coordinate services for clients. Where possible, Health Services and Health District

staff plan services at the local level with federally funded health centers for both preventive and primary care for pregnant women, infants and children. In addition, Health Services reviews and supports perinatal plans for federally funded health centers. Since 2000, SC has increased from three to seven of our twenty centers having an oral health component. Coordination of service provision varies across centers.

SC Department of Alcohol and Other Drug Abuse Services (DAODAS): DAODAS is a separate state agency. Coordination of activities takes place on specific issues and/or by program as needed.

SC Department of Disabilities and Special Needs (DDSN): The Division of CSHCN, including BabyNet, works very closely with DDSN in the coordination of care for children eligible for their respective programs. DDSN has worked closely in the development of the delivery system for infants and toddlers with developmental delays and their families. They are an essential partner in the area of care coordination for children with special needs.

Healthy Start: All three of SC's federally funded Healthy Start projects have received continued funding. They are:
1.Pee Dee Healthy Start, Inc. This project is the successor to the earlier Pee Dee Healthy Start Project sponsored through the SC United Way. The project is now managed through a consortium with 501.c.3. nonprofit organizational status. Project activities focus on rural outreach with the service area being comprised of Chesterfield, Darlington, Dillon, Marlboro, Marion and Williamsburg counties.
2.Palmetto Healthy Start. This consortium is led by Palmetto Health Alliance (Richland Memorial Hospital). Members of the collaborative include Community Health Partners, Eau Claire Cooperative Health, Richland Community Health Care Association, Inc., Benedict College, the March of Dimes, Richland County Health Department and Richland County Department of Social Services. The project goal is to reduce infant mortality and improve the well being of women, infants, children and families in Richland and Fairfield Counties.
3.Low Country Healthy Start. This project, administered through the SC State Office of Rural Health, is a community-based effort that aims to improve infant mortality and improve pregnancy outcomes in Allendale, Bamberg, Hampton and Orangeburg, all predominantly rural counties. This project has utilized contracts with existing agencies as a primary means of expanding and strengthening resources.

Department of Education (DOE): The Division of Women and Children's Services provides consultation to the Department, school nurses, and the Division of Adolescent and School Health in the local school districts. Implementation of programs in the Bureau of Maternal and Child Health, including Women and Children's Services and Children with Special Health Care Needs, involves interface with the DOE. At the state level, interaction primarily involves implementation of five initiatives: 1) School Nurse Program 2) Title V Designation of Schools 3) BabyNet 4) EPSDT Training 5) SC Healthy Schools Project.
Pediatric Emergency Medical System (EMS): Pediatric EMS is coordinated statewide by the Deputy Commissioner area of Health Regulations. Various MCH Divisions work on EMS issues including: maternal and infant transport, local community transportation assessment tool, protocol development, and injury surveillance. Currently, the Division
Director for CSHCN participates in planning through the EMS Advisory Committee. CSHCN staff has also worked closely with EMS staff and tertiary emergency room physicians to develop a portable emergency plan of care for CSHCN.

Standing Advisory Councils/Committees/Task Forces:
Various Standing Advisory Councils/Committees and Task Forces exist in the state; through which planning and interagency work is accomplished to meet the needs of mothers and children in South Carolina. The attached file contains committee examples. NOTE: This list is representative, not inclusive.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

HSCI 1. The rate of children hospitalized for asthma (ICD-9 codes: 493.0-493.9) per 10,000 children less than five years of age.

The 2005 rate of children hospitalized for asthma decreased drastically to 52.2 from 72.3 in 2003. The rate has fluctuated up and down since 2000, so it is difficult to determine if this is a true decrease or not. Several activities related to asthma prevention and treatment have been incorporated into the provision of FSS over the past several years. The Bureau has just made the decision to allow a staff member to begin devoting 20% of her time and efforts to investigate the development of a children's environmental health initiative. Efforts that should help us to better define the problems, analyze data more completely, and develop interventions that decrease the incidence of this condition as well as other environmentally related conditions.

HSCI 2. The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

79.7 percent of Medicaid enrollees less than one year of age received at least one initial periodic screen in 2004. This percentage increased for the first year time in five years. It had been decreasing for the previous four years, 76.4 in 2003, 77.3 in 2002, 78.2 in 2001, and 78.8 in 2000. It is unclear to us why this indicator has increased after several years of decreasing. Less children are enrolled in Partners for Healthy Children (insurance coverage through regular Medicaid and SCHIP Medicaid expansion), active Medicaid redetermination process was enacted for Medicaid and SCHIP, less children are receiving services through public health clinics, and fewer public health partnerships exist with private physician offices.

HSCI 3. The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

The SCHIP program in our state is a Medicaid expansion, and unfortunately, our state cannot separate SCHIP children from regular Medicaid enrolled children. Therefore, we are not able to report on this system capacity measure at this time. Due to the budget shortfalls, the Medicaid agency has implemented an active redetemination process for children and families, co-pays for services (MCH services exempt); and developed over thirty possible actions that could be implemented in the future if the budget is less than necessary to fund current services.

HSCI 4. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

During 2005, this percentage increased slightly to 84.6 percent but has fluctuated up and down since 2000, ranging from 81.4 to 84.6 over the past 5 years.

HSCI 5. Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state.

The state is very fortunate in that the MCH Bureau has a wonderful relationship with our vital records office, the state Office of Research and Statistics (ORS), and DHHS (Medicaid Agency). ORS has the legislative responsibility to "host" all state data. DHEC, ORS and DHHS have a 3-way Memorandum of Agreement (MOA) to share and link data on a request and approval basis of all three agencies. MCH and ORS have a second data sharing MOA that allows the sharing and linking of MCH data with other data by request and approval by ORS.

Comparing the health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations reveals that for 2003, the health status indicators for the Medicaid population are generally less favorable than the non-Medicaid for all populations. We are not able to link data sets to

determine if there is a difference for infant deaths per live births. Hopefully, we will be able to link these data sets in the future and be able to compare these indicators across these populations.

An increased percentage of Medicaid infants are born with a low birth weight (2,500 grams), 11.6 percent verses 8.2 percent for non-Medicaid and 10.1 percent for all; less infants are born to pregnant women who receive prenatal care beginning in the first trimester, 70.1 for Medicaid verses 83.4 for non-Medicaid and 76.2 for all; and fewer pregnant Medicaid women receive adequate prenatal care as measured by the Kotelchuck Index, 57.6 percent Medicaid verses 90.1 percent for non-Medicaid, and 73.1 percent for all.

HSCI 6. The percent of poverty level for eligibility in the State's Medicaid and S-CHIP programs for infants (0-1), children, and pregnant women.

South Carolina's S-CHIP program is a Medicaid expansion. Over the past several years, the state has experienced declining revenues and budgets. This has prevented the state from identifying sufficient state dollars to designate as state match in order to "draw down" federal dollars for Medicaid and/or S-CHIP Medicaid eligibility expansions. The state's Medicaid and S-CHIP Medicaid eligibility for pregnant women and infants remains at 185 % of the federal poverty level (FPL). For children, FPL remains at 150 % even though, in 2000, an expansion was legislatively approved at 165% FPL. At the current time, the state has not maximized its Medicaid or S-CHIP expansion opportunities due to state budgetary constraints. Lastly, the state has not decided to change the SCHIP definition of child to include the interval from conception, therefore missing the opportunity to provide prenatal care to women and their developing infant as early as possible.

HSCI 7. The percent of EPSDT eligible children aged 6 through 9 who have received any dental services during the year.

56.4 percent of EPSDT eligible children aged 6-9 received any dental services in 2004, an increase from 55.9 in 2003. The Oral Health Division has made great strides in the past several years through partnering with the Medicaid agency, private dentists, private dental hygienists, the State Dental School at MUSC, and schools to increase the number of providers, number of children receiving dental services, Medicaid reimbursement rate, and the level of understanding of parents as to the importance of early and preventive oral health services.

HSCI 8. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs Program.

In 2004, the percent of State SSI beneficiaries who received a service from the CRS program decreased to 18.4 from 20.4. This percentage has been decreasing steadily since 2000 when it was at 30.1. Recipients of SSI are referred to BabyNet, Commission for the Blind, Department of Disabilities and Special Needs, Department of Mental Health, DHEC CRS Program, Family Support Services, State Cancer Program and the Ryan White Program.

HSCI 9A. The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

The state MCH staff have developed strong relationships with our state office of vital records and our State Office of Research and Statistics to assist us in ensuring that we have access to relevant information and data. They have previously assisted the Bureau by "cleaning, unduplicating, deidentifying, linking, and matching" our MCH data with other MCH, vital records, and Medicaid data. This process resulted in identifying the WIC data set as being the most complete with the other data sets (Family Planning, Child Health, Immunization) being identified as incomplete and not worthy of linking with other data. Therefore, the linking of MCH data sets across programs is not feasible at this time. The Bureau will reexamine the linking of MCH programmatic data sets after the new automated client data system the Agency is developing.

Several advancements in 2004 and 2005 have increased the state and Agency data collection and linkage capacities. In January 2004, the state implemented an electronic birth certificate, and during the past year, the state started the implementation of a new electronic lab data system. These two electronic systems will enable the state to link birth certificates to newborn screening. Also, the 2004 state legislature passed legislation to develop and establish a birth defects surveillance system. Implementation planning is beginning for this new system, including the employment of a coordinator for this system and the seeking of funds to support this new program.

HSCI 9B. The ability of states to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

The State Department of Education conducts the YRBS every two years with the survey being conducted in 2005. The state does not participate every year. MCH has access to this data, however, the 2003 data sample size was insufficient to be used for analysis. In addition, the SC Tobacco Control Program staff Epidemiologist will be conducting the Youth Tobacco Survey (YTS), which will measure tobacco use behavior among both high school and middle school students.

HSCI 9C. The ability of States to determine the percent of children who are obese or overweight.

The state participates in and has access to health data from the CDC Pediatric Nutrition Surveillance (PedNS) data system. This data set is composed of WIC data only, no other child health or EPSDT data is included. Therefore, this data will only be reflective of a sub-population of the children in our state.

## IV. Priorities, Performance and Program Activities

### A. Background and Overview

The state has identified the MCH public health needs by the levels of the MCH pyramid and they are discussed below. The MCH pyramid is included in the attached file.

Direct Health Care Services
The greatest needs under direct health care services are related to 1) need for increased funding for insurance coverage, and 2) increased number of health care providers to deliver services.

In 2000, the state Legislature approved expansion of income eligibility for the state SCHIP program for children to 165% of the federal poverty level (FPL). This expansion has been postponed because of state budget cutbacks, and remains at 150% of the FPL. The number of families with no health insurance coverage decreased in 2001 due to increased enrollment in Medicaid and the Medicaid expansion through SCHIP. Payment for services for Hispanics whose undocumented status makes them ineligible for Medicaid is an increasing drain on health department resources.

More providers of primary, specialty, and sub-specialty care are needed. The Medicaid program intends to address state budget cutbacks in part by reducing reimbursement to all physicians, a decision that will make recruiting providers for private/public partnerships even more difficult. Rural areas are especially in need of health care providers of all types.

Enabling Services
Provision of family support services (FSS) through local public/private partnerships has great priority. Staffing of public health nurses, social workers, health educators and dieticians to work with families and patients in both home and community settings must be maintained. The goal of linking all children to medical homes promotes access to primary care as well as helps to decrease disparities in the health status of children of minority races and populations.

Population-Based Services

Population-based services in SC focus on 1) preventive health care programs and 2) educational efforts. Maintaining funding and resources in a climate of budget cutbacks has high priority, i.e., immunizations, newborn home visits, and school health nurses. In addition, addressing priority health issues that greatly affect mortality and morbidity in the total population include:

-Poor nutrition and obesity. The nutritional status of women, infants, children, and youth needs improvement.
-Injuries. Injury rates, especially for motor vehicle crashes, should be monitored to identify problem areas in the state.
-Substance abuse. Efforts to reduce the prevalence of drug and alcohol use, including smoking and smokeless tobacco, especially among adolescents, are needed.
-Unintended pregnancy. A long-standing issue that is often negatively associated with birth outcomes, perinatal health, school readiness, food security and general well being, needs continued focus.

Infrastructure Development

Public health infrastructure must be strengthened in South Carolina. A strong infrastructure is critical in carrying out essential public health services. Public health systems must include state and local public health organizations working in partnership with private entities to assure the public receives essential health services. Much more coordination and collaboration among agencies, public and private service providers, and organizations is needed. Strengthening links between these separate entities will promote better program planning and evaluation, policy development, monitoring and quality assurance, as well as better health services delivery for all.

# IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

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## B. STATE PRIORITIES

The 2005 needs assessment process was started in August 2004 with the establishment of a core planning group, who identified external stakeholders, created three workgroups, established methods for the workgroups to follow, and created scripts for the workgroups to ensure consistency. Recorders were selected and given uniform worksheets, so minutes would be comparable. The first step for the workgroups meetings was to generate the data books -- which, unfortunately, were late, difficult to access and understand, and difficult to relate to the final decision-making in the selection of priorities. Eventually the data books were available, and the workgroups met and reviewed to data.

One month later, the three workgroups met to discuss capacity, and the following month, data and capacity were reviewed and a combined group made up of the three workgroups selected 12 priorities. That meeting turned out to be contentious. In a follow-up planning meeting with the core planning group, a decision was made to empower the Needs Assessment coordinator and his graduate research assistant to select the priorities and complete the needs assessment. The 10 priorities were selected from the 30 priorities that the workgroups had generated in the morning of the third meeting. Information from a variety of Maternal and Child Health task forces, advisory committees, collaboratives, focus groups, Web based surveys, division meetings and activities, and general discussions was included to select the 10 priorities. Review of these inputs lead to a general understanding of capacity and informed the selection of the priorities, as much as input from the workgroups. Task forces, workgroups, collaboratives, advisory committees, etc. were made up of a wide variety of state agency partners, practitioners, DHEC district representatives, and community organizations. These partners have expressed strong interest in, at least, annual meetings to review the progress made implementing the activities generated by the needs assessment priorities and the performance measurements to judge the quality of those activities. The contributions from the qualitative process of bureau member input, based on input from our collaborators, had a greater effect on priority selection than did the quantitative data we had available.

During the last Block Grant application, the process used to determine the state's priorities was somewhat similar in that five population workgroups (rather than three) were formulated, who met to craft the priorities. Input from partners and collaborators were somewhat more limited in scope and in the number and variety of contributors. The needs assessment document from 2000 was far more comprehensive than this current needs assessment. It was conducted by staff members who had been in the bureau for many years and who had much more experience in this process. Data presentation and analysis was problematic during the last needs assessment process as it was this time, which emphasizes that we need to allocate resources to create and maintain MCH epidemiologic capacity, a long term serious and significant deficiency. In the five-years since the last Block Grant application, the capacity of the Maternal and Child Health bureau has been significantly reduced, both at the central office and in the county health departments, where our services are delivered to our constituents. Budget cuts have had a dramatic impact on our capacity and ability to provide direct services, which, fortunately, does fit into our philosophical change of moving down the MCH pyramid, doing less direct service and doing more enabling, population based, and infrastructure building services, working with our partners and collaborators.

The Strengths and Needs Assessment report will be a major contributor to the development of a Epi Work Plan for the next three years, the five year Needs Assessment Work Plan, and a MCH Bureau Strategic Plan. Included in these plans will be the selection of one population (Women, Infants, Children, Adolescents, Children with Special Health Care Needs, etc) per year that has gaps in primary data collection and the selection of a method to fill these identified gaps, such as surveys of clients/care givers/providers, chart reviews, or others in order to collect missing data. The data will then be analyzed and interpreted in order to improve program planning, effectiveness, targeting, performance measures, and/or impact."

Overall, this strengths and needs assessment was very challenging for the MCH Bureau. The strengths and needs assessment will allow us to meet our mission more effectively over the next five years and will continue to influence decisions and changes within the Bureau. This assessment is not a product, but a process. We plan to re-visit our priorities regularly to reassess needs, to modify priorities, to set targets in two stages with the selection of state negotiated performance measures to

monitor progress and to set national performance out come measures, to craft activities and to reallocate resources. The bureau and agency will adopt performance management systems to monitor progress, to select appropriate activities and to allocate resources in a rational fashion. From this assessment, several strengths and weaknesses emerged. The Bureau hopes to build on the current assets, create a system to support the mission and continue to outreach to the communities in South Carolina. The selection of these 10 priorities is a step along a cyclical path, with next steps of creating targeted programs for specific populations based on data from sophisticated information and analytical systems, strengthening partnerships through collaborative leadership, reallocating our resources and helping our partners adopt appropriate practices. We then will monitor progress, follow parameters through enhanced information systems, which in turn will lead to reassessment of needs and capacity, etc. continuously.

The MCH state priorities are:
1. Improve data and surveillance systems. (Infrastructure Building Service).

2. Improve access to a coordinated system of care through a systems approach. (Infrastructure Building Service).

3. Increase access to a coordinated system of care through comprehensive medical home partnerships. (Infrastructure Building Service).

4. Decrease health disparities through the utilization of cost effective strategies monitored through a performance management system. (Infrastructure Building Service).

5. Reduce unintended pregnancies. (Enabling Service).

6. Increase the application of public health research findings to public health program planning, implementation and evaluation. (Infrastructure Building Service).

7. Increase the implementation of fetal and infant death review processes. (Population Based Service).

8. Increase the initiation and duration of breastfeeding. (Enabling Service).

9. Increase access to developmental screening for children. (Population Based Service).

10. Improve access to comprehensive risk assessments. (Population Based Service).

The Bureau has developed the following state performance measures based on these priorities.

1. Increase the percent of infant screening data systems for metabolic, hearing, birth defects, and very low birth weight linked with birth certificate data.

2. Increase the percent of newborns receiving a newborn home visit.

3. Increase the number of comprehensive medical home partnerships for pregnant women, children and CYSHCN.

4. Increase the percent of MCH programs that utilize a scorecard of measures to monitor progress.

5. Decrease the percent of family planning clients served by the health departments whose pregnancy was unintended.

6. Increase the number of MCH programs that utilized research findings to better target programs to

vulnerable populations.

7. Increase the number of health departments who implemented a review process for fetal and infant deaths.

8. Increase the percent of infants who are breastfed at birth and thereafter.

9. Increase the percent of Medicaid children less than 2 years old served in comprehensive medical home partnerships that receive a developmental screening and follow up.

10. Increase the percent of pregnant women who are health department clients who are risk assessed and referred.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 99 | 99 | 99 | 99 | 99 |
| Annual Indicator | 99.0 | 99.0 | 99.0 | 99.0 | |
| Numerator | 53026 | 52723 | 51640 | 52842 | |
| Denominator | 53562 | 53255 | 52162 | 53376 | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 99 | 99 | 99 | 99 | 99 |

**Notes - 2002**

Data is not available for 2002.
These numbers are estimates; NBS can not match up with VR.

**Notes - 2003**

Data is not available for 2004.
These numbers are estimates; NBS can not match up with VR.

**Notes - 2004**

Data is not available for 2004.
These numbers are estimates; NBS can not match up with VR.

a. Last Year's Accomplishments

South Carolina estimates that 99 percent of all newborns are screened for each test based on

the number of annual state births. The inability to link State Laboratory newborn blood screening tests with vital records data is the reason this data is an estimate.

South Carolina has made progress in the past year with electronic data collection systems for infants that will allow accurate and reliable data source reporting. The laboratory purchased an information system in the Fall of 2004. This system will provide a Windows-based reporting format for the entire public health laboratory. The first section to implement the new system will be metabolic screening. Current implementation timelines indicate full functionality for the metabolic screening section of the laboratory by the end of May 2005. Shortly thereafter, the metabolic follow-up staff in the Division of Women and Children's Services will be able to utilize the system for tracking of infants with abnormal screening results.

Metabolic screening information on infants born in previous years is expected to be added to the new database after the real time capability is functional. Therefore, starting with CY 2006 births, we expect to be able to link metabolic screening data with birth certificates to accurately report the percentage of births screened rather than providing an estimate. Depending upon the ability of the laboratory to convert screening data from previous years to the new data system, the match with birth certificate information may be able to occur for CY 2005 and CY 2004 as well.

Data match between the metabolic screening information and the birth certificate information will be a challenging process. Discrepancies between the infant's name as recorded on the metabolic screening collection form and the infant's legal name as recorded on the birth certificate may occur. It could require a significant amount of time from data systems personnel to resolve this issue. Although submitters are required to document the infant's legal name on the metabolic screening collection form, compliance varies among hospitals. Some hospitals utilize the mother's last name as the infant's last name in their data system in all situations.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue to implement the expansion of the newborn screening panel by providing consultation to hospitals, physicians, and staff. | | | X | |
| 2. Work towards the integration of the newborn metabolic screening data system with the other information systems such as vital records, newborn hearing, and birth defects. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The state is aware of this limitation and will be continuing the implementation of the new

laboratory data system through the fall of 2005. The new sysytem will enable the linkage of newborn screening data to vital records. Therefore, in the future, we will be able to accurately report this number and not use an estimate.

### c. Plan for the Coming Year

This fall, the state will complete the implementation of the new laboratory data system.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 65 | 65 | 65 | 85 |
| Annual Indicator | | 61.2 | 24.8 | 83.6 | 74.1 |
| Numerator | | 336 | 204 | 905 | 630 |
| Denominator | | 549 | 821 | 1082 | 850 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 65 | 65 | 70 | 70 | 75 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.
The values "1" for annual objective to be considered not available.

**Notes - 2003**

Data for 2003 is Programmatic data from Record reviews.

**Notes - 2004**

Data source : Lisa Vousburgh CSHCN : Record reviews

SLAITS data will be used in future years, therefore, future objectives have been adjusted to reflect the use of SLAITS data.

### a. Last Year's Accomplishments

This is a quality assurance measure for the CRS Program; 2004 data from CRS record audits are used for this measure, not national SLAITS data. 2004 programmatic data indicates that 74.1 percent of families with special health care needs age 0-18 partnered in decision making at all levels and are satisfied with services they received.

In future years, we will switch to using SLAITS data for this measure, because we are not able

to obtain consistent and reliable record audit data for our state. Therefore, future objectives have been adjusted to use SLAITS data.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maintain and support the Patient Advisory Council and the employment of a state parent liaison and parents in Regional Health Districts. | | X | | |
| 2. Continue information, advocacy, and education efforts for parents, families and providers. | | X | | |
| 3. Work closely with families in developing and implementing a treatment plan. | X | | | |
| 4. Develop and administer a patient survey tool. | | | | X |
| 5. Assess the resources, needs, infrastructure of the Division and its programs. | | | | X |
| 6. Determine the most efficient ways to utilize resources. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The CRS program has gone through significant changes over the past year and we anticipate significant changes in the upcoming years. Several long time leadership individuals, including the director, have retired or accepted other positions in the agency. Therefore, the new Division Director has started a comprehensive assessment of the Division resources, structure, and functions.

Discussions have been initiated to reinstitute the quarterly CRS record audits for assurance of this measure. This is also a measure for the annual CRS Program Assessment that each CRS Coordinator must complete.

The program developed, with families, a Comprehensive Assessment and Treatment Plan, that must be completed with and given to families. Parents participate in decision making for the CRS Program through the Parent Advisory Council and various committees. Parents are employed as team members in all 8 Regional public health districts. The Parent Advisory Council publishes a newsletter for families with a circulation of 4000.

## c. Plan for the Coming Year

The new Division Director will contiune to conduct the comprehensive assessment of the Division resources, needs, structure, and functions.

Quarterly CRS record audits for assurance of this measure will be reimplemented.

Discuss the possiblility of developing and implementing a parent/consumer survey.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 92 | 94 | 95 | 95 | 95 |
| Annual Indicator | 96.3 | 88.2 | 88.2 | 83.5 | 83.5 |
| Numerator | 234 | 94632 | 94632 | 710 | 710 |
| Denominator | 243 | 107326 | 107326 | 850 | 850 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 55 | 55 | 60 | 60 | 65 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.
CRS Programmatic data.

**Notes - 2003**

Data for 2003,2004 is provisional
Source: Lisa Vousburg : CQI resord review . Dta from National SLAIT survey for 2003, 2004 is not available.

**Notes - 2004**

Data for 2003,2004 is provisional
Source: Lisa Vousburgh : CQI resord review .

SLAITS data will be used in future years, therefore, future objectives have been adjusted to relfect the use of SLAITS data.

a. Last Year's Accomplishments

The state prefers to use data from the CSHCN Data Warehouse for this measure through 2004, estimating the 2004 based on 2003 data form the ORS data warehouse. During 2004, the estimate remained the same of only 83.5 percent of Children with Special Health Care Needs (CSHCN) in the State had a medical/health home. The state did not meet the target of 95 percent. This is largely due to attempting to establish the base number of CSHCN in the State and a methodology to define what constitutes a medical home.

In future years, we will use the national SLAITS data inorder to have consistent data for trend

analysis and program planning and evaluation.

The grant that supported this effort was successful in establishing 5 partnerships that serve CSHCN children. premilinarey evaluation of this grant indicated that it demonstrated effectiveness related to children receiving more primary care visits and less hospitalization costs.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Expand the number of medical home partnerships. | | | | X |
| 2. Train parents of CSHCN in the importance of utilizing a medical home. | | X | | |
| 3. Expand the number of CSHCN served in medical home partnerships. | X | | | |
| 4. Assess the resources, needs, infrastructure of the Division and its programs. | | | | X |
| 5. Determine the most efficient ways to utilize resources. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

1. Continue to recruit physicians and practices to serve as medical homes for all children, especially CSHCN children
2. Train parents of CSHCN in the importance of utilizing a medical home.
3. Process of implementing the recently awarded HRSA integrated system grant that the state received to continue and expand medical homes as well as ensure that there is a coordinated health care system for children.

## c. Plan for the Coming Year

SC is collaborating with the Office of Research and Statistics, Budget and Control Board (the organization that houses the CSHCN Data Warehouse) to update the number of CSHCN in the State. The recently awarded integrated health care system grant will be utilized to continue and expand medical homes for children, especially CSHCN children. Additional dedicated staff will be employed in the MCH Bureau to work across Divisions to concentrate on enhancing and expanding medical homes. Continue to provide training to parents in the importance of proper utilization of the medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 92 | 93 | 94 | 95 | 90 |
| Annual Indicator | 92.0 | 92.0 | 91.3 | 88.0 | 91.4 |
| Numerator | 10961 | 10963 | 10626 | 9636 | 12286 |
| Denominator | 11914 | 11918 | 11633 | 10944 | 13438 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 60 | 60 | 65 | 65 | 70 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.
CRS Programmatic data.

**Notes - 2003**

Data for 2003 is Programmatic data from Record reviews.

**Notes - 2004**

SLAITS data will be used in future years, therefore, future objectives have been adjusted to reflect the use of SLAITS data.

## a. Last Year's Accomplishments

The state utilizes medical record autits for this data, not national SLAITS data. In 2004, the percentage went up slightly to 91.4 percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program had a source of insurance for primary and specialty care. However, we did not meet our goal of 95 percent.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Identify, refer, and assist families with children with special health care needs who are Medicaid eligible. | | X | | |
| 2. Advocate for adequate reimbursement for pediatric sub-specialists. | | X | | |
| 3. Maintain linkages with third pary insurers to maximize coverage for children with special health care needs. | | X | | |
| 4. Assess the resources, needs, infrastructure of the Division and its | | | | X |

| | | | | |
|---|---|---|---|---|
| programs. | | | | |
| 5. Determine the most efficient ways to utilize resources. | | | | **X** |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The State CSHCN Program identifies as early as possible children with special health care needs who are potentially Medicaid eligible and refers and assists these children and their families in obtaining Medicaid coverage. The Program maintains linkages with third party insurance carriers and assists families in coordinating coverage for needed medical services. The State CSHCN program has participated in advocating for adequate reimbursement for pediatric

c. Plan for the Coming Year

The State CSHCN Program will continue the activities identified in b) above in the next year. The Division Director will continue the comprehensive assessment of the resources, needs, and infrastructure of the CRS program and the Division inorder to determine the most efficient use of available resources.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 75 | 75 | 80 | 80 |
| Annual Indicator | | 73.8 | 72.1 | 76.5 | 76.5 |
| Numerator | | 336 | 592 | 828 | 828 |
| Denominator | | 455 | 821 | 1082 | 1082 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 75 | 80 | 80 | 85 | 85 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

Data for 2003 is Programmatic data from Record reviews.

**Notes - 2004**

The data reported in 2003 was also used for 2004.

SLAITS data will be used in future years, therefore, future objectives have been adjusted to reflect the use of SLAITS data.

## a. Last Year's Accomplishments

This is a quality assurance measure for the CRS Program; data from CRS record audits was used for 2003 and 2004, not national SLAITS data. In 2003 and 2004, 76.5 percent of families with children with special health care needs age 0 to 18 report the community-based service systems are organized so they can use them easily. This is an increase from 72.1, and almost met our goal of 80 percent.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continue tertiary and medical home partnership development. | | | | X |
| 2. Continue to develop case management eforts through the medical home. | | X | | |
| 3. Develop and administer the client survey tool. | | | | X |
| 4. Assess the resources, needs, infrastructure of the Division and its programs. | | | | X |
| 5. Determine the most efficient ways to utilize resources. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

This is also a measure for the annual CRS Program Assessment and an established competency for the CRS Coordinator. The interagency work group for the CSHCN Data Warehouse is also looking at this issue from a utilization and geographic perspective. The CRS Program also provides clinics and itinerant clinics where there is unmet need, develops tertiary partnerships to assure specialty care, and is in the process of expanding medical home partnerships. The program offers case management through the CRS staff and DHEC Family Support Services.

## c. Plan for the Coming Year

The program will increase public/private partnerships to increase access to medical homes. It will also address this measure through the CSHCN Data warehouse, parent survey and

maintain other efforts.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 11 | 20 | 25 | 30 |
| Annual Indicator | | 7.1 | 5.8 | 90.0 | 90.0 |
| Numerator | | 101 | 32 | 974 | 974 |
| Denominator | | 1423 | 548 | 1082 | 1082 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 7 | 7 | 10 | 10 | 10 |

**Notes - 2002**

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

**Notes - 2003**

Data for 2003 is Programmatic data from Record reviews.

**Notes - 2004**

The data reported in 2003 was used for 2004.

SLAITS data will be used in future years, therefore, future objectives have been adjusted to reflect the use of SLAITS data.

a. Last Year's Accomplishments

The program utilized reviews of medical records for 2003 and 2004 data, not national SLAITS data. In previous years, SLAITS was used. Therefore, trends can not be inferred from this data over these last four years. In 2003 and 2004, 90 percent of families interviewed felt they had received services necessary to make transitions to all aspects of life.

In future years, the state will return to using SLAITS data inorder to have consistent and reliable data for evaluaiton, program planning and trend analysis.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| | **Pyramid Level of** |
|---|---|

| Activities | Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maintain transition coordinator, coordination and training efforts. | | X | | |
| 2. Work through parents to develop a strong training component for families. | | X | | |
| 3. Develop and administer the client surey tool. | | | | X |
| 4. Expand and enhance interagency collaboration. | | | | X |
| 5. Assess the resources, needs, infrastructure of the Division and its programs. | | | | X |
| 6. Determine the most efficient ways to utilize resources. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Since 2002, the CRS Program has employed a transition coordinator who works closely with the CRS Program, Parent Advisory Council, BabyNet, Sickle Cell Foundation, and interagency groups to develop systems for transition. She also serves on the Office of the Governor's transition Work Group. In addition, the Parent Liaison and the Transition Coordinator provide intense training to families, consumers and staff who work with CSHCN. This is also a quality measure for the CRS Program and a measure for the CRS Program Assessment.

The program also has an agreement with the Department of Vocational Rehabilitation to improve school-to-work transition services through both agencies.

Consultation and technical assistance for school nurses and other school staff are also being provided currently.

c. Plan for the Coming Year

The CRS Program will maintain these efforts plus include this measure in the parent survey. Expanding and enhancing interagency collaboration around CSHCN services is also planned for the upcoming year.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|

| Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |
| Annual Indicator | 87.7 | 87.1 | 83.3 | 84.3 | 80.5 |
| Numerator | 92850 | 93375 | 88798 | 93449 | 90088 |
| Denominator | 105872 | 107205 | 106600 | 110852 | 111910 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 85 | 90 | 90 | 90 | 90 |

**Notes - 2002**

The data from 2002 SC state survey ( 73% )provided by Imm Dept. is provisional, pending review. The number provided for 2002,2003 and 2004 should be considered estimates as they are from NIS ( CDC web-reports). Numerators and denomianators are estimates provided by ORC census data. Data is for the period Q3,2002-Q2,2003

**Notes - 2003**

The data from SC state survey ( 73% )provided by Imm Dept. is provisional, pending review. The number provided for 2002,2003 and 2004 should be considered estimates as they are from NIS ( CDC web-reports). Numerators and denomianators are estimates provided by ORC census data. Data is for the period Q1,2003-Q4,2003

**Notes - 2004**

The data from 2002 SC state survey ( 73% )provided by Imm Dept. is provisional, pending review. The number provided for 2002,2003 and 2004 should be considered estimates as they are from NIS ( CDC web-reports). Numerators and denomianators are estimates provided by ORC census data. Data is for the period Q3,2003-Q2,2004 and this is the most recent data available.

## a. Last Year's Accomplishments

South Carolina continues to achieve very high levels of immunization in its two-year-old population. The latest (Spring 2001) population survey indicated that 87.1 percent of two year olds were fully immunized. The 2002 survey is not available yet, so there is no new data.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Maintain vacination coverage (DTaP, MMR, Polio) at 95% for children in licensed day care facilities. | | | **X** | |
| 2. Vaccination coverage levels for universally recommended vaccines among preschool children are maintained. | | | **X** | |
| 3. Vaccine information statements (VISs), misconceptions about | | | **X** | |

| | | | | |
|---|---|---|---|---|
| immunizations and DHEC immunizaton required are kept up to date. | | | | |
| 4. Reduce Vaccine-Preventable Disease and maintain an active surveillance system. | | | | **X** |
| 5. -promote the medical home concept with emphasis on promoting Standards for Child and Adolescent Immunization Practices and improving immunization coverage rates | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The state continues to work on the following interrelated strategies:
-enhance the quality and quantity of vaccination delivery services (through increasing access to immunizations in DHEC and non-DHEC clinic and provider sites) and through training for all immunization providers in the state
-reduce vaccine costs for parents
-increase community participation, education, and partnerships
-improve the monitoring of disease and vaccination coverage
-improve vaccines and vaccine use.
-promote the medical home concept with emphasis on promoting Standards for Child and Adolescent Immunization Practices and improving immunization coverage rates

c. Plan for the Coming Year

The target for next year is to maintain at least a 90 percent level through interventions that sustain the ongoing success that the state has had.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 36 | 34.4 | 28 | 27 | 26 |
| Annual Indicator | 33.6 | 29.9 | 28.7 | 28.8 | 28.1 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Numerator | 2915 | 2625 | 2379 | 2435 | 2424 |
| Denominator | 86750 | 87802 | 83016 | 84494 | 86262 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 26 | 26 | 25 | 25 | 24 |

**Notes - 2004**

The provided nuimbers should be considered estimates. Pending 2004 dataset to be completed; Population est. as of July, 2004 are used and 2003 distribution of gender is applied for the calculations.

## a. Last Year's Accomplishments

The 2003 rate has increased slightly to 28.8 percent from 28.7 in 2002. the 2003 provisional data indicates a 3 year rate that may be levelling off at 28 percent. Initiatives and activities that contributed to this decrease are increased awareness by teens of the dangers of risk taking behaviors, abstinence education programs, and teen pregnancy prevention councils across the state who, along with other community providers and the local health department do an excellent job of getting the word out. The availability of a broad range of contraceptive methods including depo provera, emergency contraception, the "patch" and other methods also enhance the likelihood that a teen can find something suitable to his/her needs.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Work with the Teen Pregnancy Prevention Campaign, to promote awareness through media campaigns and providers. | | | **X** | |
| 2. Initiate a youth development project in at least one county. | **X** | | | |
| 3. Collaborate with the community groups and schools in providing supportive servcies in addition to clinical services. | | | | **X** |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

A statewide effort has been undertaken to evaluate the efficiency of service delivery in DHEC Family Planning clinics. As a result of this evaluation, a full set of recommendations have been made by Health Metrics. All health regions have implemented the recommendations to some extent and are meeting with success. Show rates have improved from around 40-45% to nearly 70-95% with open access scheduling. Such activities that promote efficiency will also contribute

to better customer service.

### c. Plan for the Coming Year

The target for HP 2010 at 43.0 has been met. The goal for the state is to continue to improve the teen pregnancy rate so that the state is ranked in the top 25 states for teen pregnancy rates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 45 | 45 | 45 | 25 | 30 |
| Annual Indicator | 10.6 | 13.9 | 19.6 | 27.4 | 31.8 |
| Numerator | 6252 | 9026 | 2134 | 3518 | 11627 |
| Denominator | 58872 | 64739 | 10870 | 12856 | 36620 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 35 | 40 | 45 | 50 | 50 |

**Notes - 2002**

The source of performance data for this measure changed in 2000. Prior to 2000, the performance data was an estimate based on public school enrollment and a survey of dentists. This method resulted in a very inaccurate performance estimate. Starting In 2000, the Oral Health Division began conducting a survey of the oral health status of public school children, which resulted in performance data that is more accurate.

**Notes - 2003**

The provider of the data (Oral Health) cautions that the numbers for 2003 can be biased, because the data is from school based programs for sealants.

**Notes - 2004**

Provisional data.The provider of the data (Oral Health) cautions that the numbers for 2004 can be biased, because the data is from school based programs for sealants and may include some 7-th graders.

### a. Last Year's Accomplishments

2004 saw another year with a dramatic increase to 31.8 percent from 27.4 of third grade children who have received protective sealants on at least one permanent molar tooth. This

increase is a reflection of the newly established partnership program for school-based dental services.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Work with organized dentistry, hygienists and local schools to expand partnershuips to target school children. | | | | X |
| 2. Establish standard forms and evaluation process for all participating providers including data reports. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Expansion efforts are currently underway statewide.

c. Plan for the Coming Year

Planned activities for next year will be to work with organized dentistry, hygienists and local schools to expand partnerships to target schools; establish standard forms and evaluation process for all participating providers including data reporting requirements.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 7.4 | 7.4 | 6.5 | 6.5 | 6.5 |
| Annual Indicator | 6.6 | 6.3 | 6.9 | 4.3 | 3.7 |
| Numerator | 52 | 50 | 52 | 34 | 29 |
| Denominator | 787470 | 797316 | 758725 | 794631 | 791323 |
| | | | | | |

| Is the Data Provisional or Final? | | | | Final | Provisional |
|---|---|---|---|---|---|
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 3.6 | 3.6 | 3.6 | 3.5 | 3.5 |

**Notes - 2003**

This measure is for age group 1-14.

**Notes - 2004**

Provided numbers to be considered estimates. Pending 2004 Death file to be completed. Population data are estimates as of July, 2004.

## a. Last Year's Accomplishments

In 2003 the rate decreased to 4.3 from 6.3 in 2002 of deaths to children aged 0-14 caused by motor vehicle crashes per 100,000 children. This decrease is probably due to increased awareness and education to parents, caregivers etc. Each year more certified technicians are trained and are readily available to inspect safety seats for correct use.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide public education on the new Primary seatbelt law. | | **X** | | |
| 2. Conduct Hispanic/Latino safety seat events. | **X** | | | |
| 3. Conduct informal seatbelt surveys in all 46 county health departments. | | | | **X** |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The program currently provides:
-parental and community group counseling on child passenger seats
-distribution of child passenger seats
-demonstration and instruction of the proper installation of the various child safety seats (infant, convertible, and booster seats)at various public health events and in four permanent fitting stations in allhealth regions
-instruction about the dynamics of a motor vehicle crash and the potential dangers to children not properly restrained
-training to health regions, partner organizations, and community groups to ensure knowledge and skills to properly restrain children in motor vehicles and adult seatbelt usage
-technical assistance to the health regions and the community
-technical assistance to SCPHA bicycle helmet program.

c. Plan for the Coming Year

The program plans to:
-distribute child passenger seats
-establish fitting stations with non-traditional partners
- build infrastructure for CPS education in Hispanic/Latino communities throughout the state
-conduct a minimum of 36 presentations reaching an estimated 700 people, regarding the proper use of seatbelts and child restraint devices
-conduct or participate in a minimum of 12 NHTSA Certified Technician classes
-plan and conduct educational activities in support of National Child Passenger Safety Week (February) and Buckle Up America Week (May)
-conduct or participate in a minimum of 36 child safety seat check-up events
-fully participate in the state's Occupant Protection Program throughout the grant period, to include the Fasten for Life mobilizations.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 37 | 35 | 50 | 50 | 50 |
| Annual Indicator | 48.2 | 52.7 | 53.8 | 56.3 | 56.3 |
| Numerator | 23164 | 25522 | 25878 | 30050 | 30511 |
| Denominator | 48089 | 48429 | 48100 | 53376 | 54219 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 60 | 60 | 65 | 65 | 65 |

**Notes - 2002**

Data not available for 2002.

**Notes - 2003**

Data provided is provisional. Birth dataset had included new variable " BREASTFED" : if babies were breastfed at the hospital, beginning from 2004. There is no data for 2003 available from PRAMS and the percentage for 2003 is an estimation using as denominator the occurrent live births for 2003.

**Notes - 2004**

Data provided is provisional (Pending completion of 2004 Birth file). Birth dataset had included new variable " BREASTFED" : if babies were breastfed at the hospital, beginning from 2004. Numerator: Number of moms, who breast-fed their babies; the denominator : Number of occurrent live births.

## a. Last Year's Accomplishments

The state has changed to using data retrieved from the electronic birth certificate. In January, 2004, SC implemented an electronic birth certificate with all 48 birthing hospitals submitting data electronically. Provisional data for 2003 and 2004, indicate that the percentage increased to 56.3 for both years from 53.8 of infants breastfed at hospital discharge.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Expansion of the breastfeeding peer counselor program. | | X | | |
| 2. Increase the accuracy of collecting WIC breastfeeding data. | | X | | |
| 3. Provide training to district staff including clerical staff that input WIC breastfeeding data. | | X | | |
| 4. Provide statewide updates/trainings to district Breastfeeding Coordinators to include: a)working with Hispanic population, b)use of peer counselors to increase breastfeeding rates. | | X | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Each local health district must designate a staff member as the breastfeeding coordinator. This staff coordinates breastfeeding promotion and support activities. Local health districts also use breastfeeding peer counselors to provide one-on-one support to promote and increase the duration of breastfeeding. All local health districts provide an opportunity for each pregnant woman to attend a breastfeeding nutrition education class. Task appropriate breastfeeding education is provided for WIC health professionals to assure that updated and appropriate breastfeeding education is provided to pregnant and breastfeeding women and appropriate information is provided for breastfed infants.

State and regional staff actively participate and support the SC Breastfeeding Coalition as well as the five regional breastfeeding coalitions that promote breastfeeding in communities across the state. Regional and state WIC staff are collaboratively working with Health Serivces and Bureau of Informaiton System staff to develop a WIC module within the new computer system, Client Automated Record and Encounter System (CARES), to accuratley capture the rate and duration of breastfeeding.

## c. Plan for the Coming Year

Activities planned for the upcoming year include:
-Expansion of the breastfeeding peer counselor program.
-Implementatin of a WIC module within the new computer system, Client Automated Record and Encounter System (CARES), to accuratley capture the rate and duration of breastfeeding.
-Provide statewide training and support to regional and county staff on this module to ensure its accuracy and completeness.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 60 | 77 | 98 | 99 | 100 |
| Annual Indicator | 41.2 | 95.0 | 98.4 | 98.1 | 98.4 |
| Numerator | 23299 | 37042 | 49210 | 50516 | 52376 |
| Denominator | 56563 | 38990 | 50010 | 51488 | 53216 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

a. Last Year's Accomplishments

In 2004, the percentage of infants screened for hearing loss before hospital discharge increased slightly to 98.4 percent, exceeding the state target of 98 percent and the American Academy of Pediatrics target of 95 percent. Additionally, there has been a 29.6 percent increase to 82 percent in the number of infants identified with hearing loss being referred to early intervention by 6 months as a result of internalized the referral process at the central office.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Visit hospitals to review protocols and procedures for reporting information to First Sound. | | | | X |
| 2. Present information to community and medical providers on the | | | X | |

| | | | | |
|---|---|---|---|---|
| importance of universal newborn hearing screening. | | | | |
| 3. Develop monitoring and assessment tool to measure screening and evaluation outcomes for newborn hearing screening. | | | | X |
| 4. Develop an integration model to link with vital records data to increase the overall accuracy of dat collected. | | | | X |
| 5. Continue outreach to primary care providers to review and monitor compliance with protocols and procedures. | | | | X |
| 6. Focus on decresing lost ot follow up rate by establishing parent support network for parents of children with hearing loss. | | | X | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

### b. Current Activities

Currently, the First Sound Program is continuing to provide training on navigating the electronic reporting system to hospitals and audiologists as needed for review and employee turnover. First Sound staff has also been involved in integrating its data with the vital records birth data system to increase the overall accuracy of the program's data. Because of a reduction in audiology providers willing to accept Medicaid patients, the First Sound Program Manager has been working with a group of audiologists to facilitate possible updates in Medicaid reimbursement for audiological services.

### c. Plan for the Coming Year

Activities planned for the coming year include:

Development of an integration model to link with the vital records birth data system for an overall increase in the accuracy of the program's data.

Continued outreach to primary care physicians to increase awareness of the importance of universal newborn hearing screening and increase access to a medical home for those infants identified with a hearing loss.

Continued site visits to hospitals and audiologists to review and monitor compliance with established protocols and procedures.

Focus on decreasing the program's lost to follow up rate by establishing a parent support network for parents with children with hearing loss.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Performance Objective | 13 | 12.3 | 12 | 10 | 10 |
| Annual Indicator | 12.7 | 9.9 | 6.9 | 9.0 | |
| Numerator | 128000 | 101000 | 69000 | 92000 | |
| Denominator | 1009641 | 1016000 | 998000 | 1027000 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 8 | 8 | 8 | 7 | 7 |

**Notes - 2002**

Data not available for 2002.

**Notes - 2003**

The data is provided from Census Bureau, CPS . Numbers are estimated.
Data for 2003 is not available.

**Notes - 2004**

Data for 2004 is not available yet.

## a. Last Year's Accomplishments

Based on CPS estimates of the uninsured under 200 percent of poverty population for 2003, 9.0 percent of children were uninsured in the state, exceeding our goal of 10 percent. This percentage is a large increase from the previous year, 6.9 percent in 2002. It is very difficult to identify some of the factors for this increase, but there have been several decisions and changes in the state that may have contributed to this increase.

Some of the factors that may have contributed are that the:

-economy had not started to improve, resulting in more unemployment and less insurance coverage for families and children
-Medicaid eligibility process was changed to be more cumbersome
-Medicaid implemented an active eligibility redetermination process
-Medicaid implemented co-pays (MCH populations are exempt)
-fewer out-stationed workers in provider areas, especially in local health departments
-discontinuation of the EPSDT administrative outreach contract with DHEC in 2002
-more managed care options being implemented by Medicaid.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Continue to nurture existing and develop new partnerships in order to ensure that there are adequate providers to serve Medicaid and low income children in a coordinated system of care. | | | | **X** |
| 2. Continue to educate legislators, the Medicaid Agency and other | | | | |

| | | | | |
|---|---|---|---|---|
| advocates to expand eligibility for Medicaid and SCHIP. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Current Activities:
Regional and county staff continue to educate families and clients on the availability and eligibility criteria for Medicaid.

MCH staff continue to nurture existing and develop new partnerships with private and non-profit providers to improve access to services and to ensure that there is a coordinated system of care for children.

MCH staff continue to educate legislators, the Medicaid Agency and other advocates to expand eligibility in the state. For children, FPL remains at 150 % even though, in 2000, an expansion was legislatively approved at 165% FPL.

c. Plan for the Coming Year

As stated above, the state and regions will:
-continue to nurture existing and develop new partnerships
-continue to develor partnerships that could become PCCM partnerships
-continue to educate legislators, the Medicaid Agency and other advocates to expand eligibility.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 88 | 96 | 85 | 85 | 85 |
| Annual Indicator | 87.3 | 83.0 | 83.6 | 85.4 | |
| Numerator | 306616 | 343105 | 349503 | 328027 | |
| Denominator | 351362 | 413153 | 418000 | 384000 | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |

| | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|
| Annual Performance Objective | 87 | 87 | 90 | 90 | 95 |

**Notes - 2002**

Data not available for 2002.

**Notes - 2003**

Tne number in the numerator excludes those children who were SCHIP eligible at any point in State Fiscal Year 2002. Denominator is for CY2003 children (<19) at or below 200% poverty, and numerator is for FY 2003.
Data for 2004 is not available.

**Notes - 2004**

Tne number in the numerator excludes those children who were SCHIP eligible at any point in State Fiscal Year 2002
Data for 2004 is not available.

## a. Last Year's Accomplishments

Based on estimates provided by the Medicaid agency, and using the latest HCFA available 2082 report, provisional data for 2003 indicated that the number of children potentially eligible for a Medicaid service who received a service increased to 85.4 percent. This was a slight increase from 83.6 percent in 2002. This is provisional data and the increase in the percentage of children who actually received a service is somewhat misleading and should not be interpreted as a positive improvement. This statement is based on the provisional data that indicates the number of children eligible and the number of services provided have both decreased in the state.

The number of potentially eligible children decreased by 8.2% (384,000 verses 418,000) and the number of eligibles who received a service decreased by 6.1% (328,027 verses 349,503).

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Participate via contract in the newest managed care initiative (PCCM) in the upstate. | | X | | |
| 2. Meet with the other 2 management vendors for the other PCCM pilots to contract with DHEC. | | X | | |
| 3. Continue to nurture existing and develop new partnerships in order to ensure that there are adequate providers to serve Medicaid and low income children. | | X | | |
| 4. | | | | |
| 5. | | | | |
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| 10. | | | | | |

b. Current Activities

South Carolina is placing tremendous effort on assisting clients to retain and appropriately utilize Medicaid and linking these enrolled children to primary care services. Unfortunately, the number of private/public partnerships has decreased to less than 50. This decrease can be partially attributed to the decreased budgets that state agencies, regions and counties have experienced, increased turnover in public health positions, and the decresed numbers of public health employees.

Even with these partnerships, there is still a need to continue to provide comprehensive well childcare in some of our county health departments. Most counties have transitioned out of the provision of EPSDT but in a few regions, EPSDT services, as well as some services to uninsured clients are still provided.

As stated previously, DHEC staff continue to concentrate on promoting utilization for children already eligible for Medicaid and SCHIP through the mega Medicaid contract and the provision of Family Support Services.

Starting July 2005, DHEC will have a contract with the management vendor for the three upstate counties that are implementing the new Medicaid managed care pilot product for children entitled "Primary Care Case Management (PCCM)". This PCCM product is being designed to support the primary care physician provider and the medical home concept. The DHEC contract is for 0.5 percent of a nurse to provide care coordination and supportive services to children enrolled in the pilot to improve their health outcomes and utilization of care.

MCH staff are aggressively meeting with the other 2 management vendors for the other PCCM pilots to contract with DHEC for similar staffing and scope of services.

c. Plan for the Coming Year

For 2005 and forward, the target each year remains at 85 percent of potentially Medicaid eligible children will receive a paid Medicaid service. All eight health regions continue to emphasize private/public partnerships for medical homes for children.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 1.9 | 1.9 | 1.8 | 1.7 | 1.7 |
| Annual Indicator | 2.0 | 1.9 | 1.9 | 2.1 | 2.1 |
| Numerator | 1107 | 1056 | 1055 | 1157 | 1113 |
| Denominator | 55964 | 55748 | 54453 | 55461 | 53692 |

| Is the Data Provisional or Final? | | | | Final | Provisional |
|---|---|---|---|---|---|
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 2 | 2 | 1.8 | 1.8 | 1.8 |

**Notes - 2003**

**Notes - 2004**

Data provided for 2004 is to be considered estimation, Pending 2004 dataset to be completed. Residence data.

## a. Last Year's Accomplishments

During 2003, the percent of very low birth weights increased to 2.1 from 1.9 and provisionlly for 2004, data indicates a plateau effect at 2.1. The partnership with the SC March of Dimes to reduce prematurity provides a an opportunity to collaborate with private and public entities to more closely study the data, identify needs and target interventions in SC.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Partner with the SC March of Dimes to develop and implement campaign to prevent premature birth. | | | | **X** |
| 2. Continue partnership with the AME Church to educate and increase awareness about infant health, including low birth weight and premature births. | | | | **X** |
| 3. Health Departments will provide education to pregnant clients about the signs and symptoms of premamature labor. | **X** | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
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## b. Current Activities

Current Activities:
Most of the health districts focus on activities that promote access to prenatal care, risk assessment and utilization of supplemental foods (WIC). Several districts have Fetal and Infant Mortality Review teams and utilize information gained from that process to correct systems issues that impact this measure. There is collaboration with Healthy Start projects in selected areas throughout the state as well as the March of Dimes Program Services Committee.

## c. Plan for the Coming Year

A primary activity to reduce the percent of VLBW births in SC will be to continue the partnership

with the SC March of Dimes Campaign to prevent premature births. SC DHEC will continue to be actively involved in the development of educational and provider activities to increase awareness of the problem of premature birth. Health departments will incorporate the signs and symptoms of premature labor into their teaching curriculum for prenatal clients as the FIMR process has identified that women often do not know they are experiencing early labor and do not seek care. Also, the partnership with the African Methodist Episcopal Church Minister' s Wives and Widows Alliance will continue training to the general community on how to have healthier infants and specifically educate pregnant women about the signs and symptoms of preterm labor.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 7.8 | 7.3 | 6 | 6 | 6 |
| Annual Indicator | 6.1 | 6.0 | 6.3 | 5.5 | 7.8 |
| Numerator | 18 | 18 | 18 | 16 | 23 |
| Denominator | 295380 | 298977 | 283834 | 288841 | 293851 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 6 | 6 | 6 | 6 | 5.5 |

**Notes - 2002**

Data not available for 2002.

**Notes - 2003**

Data for 2004 is not available yet

**Notes - 2004**

Numbers for 2004 are to be considered estimates. Pending 2004 Death file to be completed. Residence data

a. Last Year's Accomplishments

According to Vital Statistics data, the rate of youth suicides in 2003 was 5.5. From 2000 to 2002 the rate had stabilized around 6.0, ie in 2000 it was 6.1, 2001 was 6.0, 2002 was 6.3. It appears that it may be stabilizing around 6.0 based on this data source.

However, preliminary data from the South Carolina Violent Death Reporting System (SCVDRS), the 2004 suicide rate for youth aged 15-19 years increased dramatically to 9.2 per 100,000. This calculation is based on a population estimate and may be affected by other factors.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Form a statewide coalition to address suicicde prevention issues. | | | | X |
| 2. Hold a walk on October 9 to promote awareness of suicide prevention. | | X | | |
| 3. Develop a directory of suicide survivior groups in SC. | | X | | |
| 4. Hold a data dissemination workshop, which will include data related to violent deaths. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Health regions have developed activities, primarily in partnership with the local county mental health centers and schools since 1999. Those activities include staff development, collaboration and coordination with local service agencies including substance abuse treatment centers, and community mental health centers. Health department staff are doing risk assessments of all patients who present for services, including youth, and making referrals to appropriate mental health services as indicated.

c. Plan for the Coming Year

The SC Suicide Prevention Task Force participated in the September 2004 SC Violence Prevention Strategic Planning Meeting. The South Carolina Suicide Prevention State Plan, which identifies youth as a vulnerable population, was released. The Task Force is in the process of transitioning into a statewide suicide prevention coalition. Other local efforts will be continued.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 78 | 77.5 | 78 | 78.5 | 82 |
| Annual Indicator | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | 77.1 | 77.1 | 80.0 | 77.3 | 77.7 |
| Numerator | 800 | 755 | 793 | 849 | 881 |
| Denominator | 1037 | 979 | 991 | 1098 | 1134 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 80 | 82 | 84 | 84 | 86 |

**Notes - 2004**

Data provided for 2004 is to be considered estimation, Pending 2004 dataset to be completed.Occurrence data.

## a. Last Year's Accomplishments

During 2003, the percent of VLBW infants delivered in Level III hospitals decreased to 77.3 from 80.0, almost meeting the target of 78.5 New hospital licensing standards and increased oversight have been effective in reversing the trend with more VLBW infants born in Level III hospitals now than 5 years ago.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Program staff will continue to monitor where VLBW infants are delivered. | | | | **X** |
| 2. Provide consultation and technical assistance to hospitals to transfer appropriate prenatals when necessary. | | | | **X** |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

At the state level, public health is focusing on the issue and identifying strategies to increase the percentage of VLBW births in Level III hospitals. All hospitals are now required by law to complete a form on every very low birth weight infant delivered in their facility and to forward a copy to the Division of Perinatal Systems.

## c. Plan for the Coming Year

The VLBW data is reviewed annually by the designated Regional Rerinatal Center staff to identify oportunities for improvement. The form will also be evaluated to determine if it can be revised inorder to be submitted as an electronic form complimentary to the electronic birth

certificate. All 48 birthing hospitals began submitting electronic birth data in January 2004.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 82.8 | 80 | 81 | 80 | 82 |
| Annual Indicator | 78.6 | 78.5 | 77.7 | 76.2 | 67.4 |
| Numerator | 43982 | 43739 | 42290 | 42248 | 36172 |
| Denominator | 55964 | 55748 | 54453 | 55461 | 53692 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 70 | 74 | 76 | 80 | 90 |

**Notes - 2004**

Data provided for 2004 is to be considered estimation, Pending 2004 dataset to be completed.Residence data.

## a. Last Year's Accomplishments

During 2003, a slight decrease from 77.7 to 76.2 percent all women entered care in the first trimester of pregnancy, the fifth year in a row of decreases. The provisional data for 2004 indicates a sixth year of decrease to 67.4.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Health deparments will provide more risk assessments at the time of positive pregnancy tests and followup prenatals to ensure entry into prenatal care. | X | | | |
| 2. Through the Caring for Tomorrow's Children Program, the importance of early and continuous prenatal care will be dessiminated. | | | X | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

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|---|---|---|---|---|
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

This is a multifaceted problem and requires work on several fronts, including accurate reporting of prenatal care entry on the birth certificate, physicians promoting the first visit during the first trimester, and thirdly, getting information to women of childbearing age regarding the importance of early entry into care. The health districts work regularly with the Regional Systems Developers, hospital vital record clerks, hospital medical records and physicians' offices to monitor the quality of data reported on birth certificates. They also have initiated and/or participated in partnerships with private providers for complementing Family Support Services to be provided to their clients.

In recent years, there has been a decrease in the number of co-located Medicaid eligibility workers in county health departments. This change is a potential barier to early entry into care.

c. Plan for the Coming Year

For 2004, the target is 80 percent. A priority acitivity for the regions has been set to follow all women from time of positive pregnancy test to entry into prenatal care. The health department stall will assist in Medicaid application process, scheduling appointments, and transportatin as needed.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percentage of Medicaid newborns in the state receiving a home visit.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 72 | 67 | 68 | 70 | 60 |
| Annual Indicator | 58.0 | 60.4 | 53.0 | 50.8 | 46.0 |
| Numerator | 14313 | 14092 | 13865 | 13323 | 12900 |
| Denominator | 24671 | 23349 | 26150 | 26210 | 28032 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 50 | 55 | 60 | 60 | 65 |

**Notes - 2002**

The data is not available for 2002.

**Notes - 2003**

Data provided by Medicaid

**Notes - 2004**

Data provoded from Heather Kirby(ORS):
The numbers are calculated as folllows:
They pulled all Medicaid paid
births from the Medicaid paid inpatient hospital claims and linked these
babies (not matched to South Carolina birth certificates) to the
Medicaid paid newborn home visits.

## a. Last Year's Accomplishments

This measure is a Direct Health Care Service, and it is classified as a Risk Factor measure. The measure looks at all Medicaid newborns receiving a home visit, regardless of who provides the service. Although newborn home visits are an increasing priority for DHEC, we also have an assurance responsibility to facilitate postpartum newborn home visits regardless of public/private affiliation of the provider. Home visits in South Carolina have been associated with improved postneonatal outcomes. Home visits contain counseling components related to behavior change and the linking of mothers and infants to providers and services. The ultimate goal is to have all newborns in the state receive a newborn home visit, but South Carolina is beginning its focus on the Medicaid population due to the higher prevalence of risk factors associated with poor health outcomes in this population. This measure is directly related to the priority need of increasing access to newborn home visits, and related to increasing access to enabling, family support services, reducing preventable injuries, and increasing access to quality risk-appropriate care. This measure is related to the neonatal, postneonatal, and infant mortality outcome measures. Public Health has continued to provide the majority of postpartum newborn home visits in our state, and all twelve health districts continue to be the primary provider of this service.

In 2004, Only 46 percent of Medicaid newborns in South Carolina received a newborn home visit. The target of 60 percent had been established. This was the third year in a row that it has decreased, 50.8 percent in 2003, 53 percent in 2002, and 60.4 in 2001. Factors that may have contributed to these decreases are the difficulties districts have had with decreased budgets, recruiting and retaining staff, and hiring freezes.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Home visits will be a priority in 2005 with follow up provided to assure linkage into medical home. | X | | | |
| 2. Continue to implement the plan for this priority with regions and counties receiving consultation. | | | | X |
| 3. Identify barriers to implementation and pose solutions in order to assure that implementation of this priority is continued and increased. | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

| | | | | |
|---|---|---|---|---|
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Newborn home visits to Medicaid infants is one of the priorities that have been identified by the state. Central office staff are providing consultation and encouragment to disricts to continue and expand their capacity to provide newborn home visits.

c. Plan for the Coming Year

South Carolina plans to increase the percent of Medicaid newborns receiving a home visit to 62 percent in 2005, increasing slightly each year to 70 percent in 2009. These increases in services are dependent on adequate funding of the state Medicaid agency (DHHS). Over time, the goal will still be to include all newborns/mothers.

State Performance Measure 2: *Percent of women giving birth in the state whose pregnancy was unintended*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 44 | 44 | 45 | 45 | 45 |
| Annual Indicator | 47.3 | 48.2 | 47.5 | NaN | NaN |
| Numerator | 23731 | 24339 | 23071 | 0 | 0 |
| Denominator | 50209 | 50496 | 48570 | 0 | 0 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 45 | 45 | 45 | 45 | 45 |

**Notes - 2002**

Data for 2003 and 2004 is not available yet.

**Notes - 2003**

Data source: PRAMS. Data for 2003 and 2004 is not available
The values of "0" and "1" are used only to be able to save the form.

**Notes - 2004**

Data is not available yet.

## a. Last Year's Accomplishments

This measure is a Population Based Health Care Service and is classified as a Risk Factor measure. Unintendedness is associated with poorer birth outcomes and greater risk behaviors by the mother. In 2002, the percentage decreased to 47.5 from 48.2 of South Carolina's births are reportedly unintended. The state did not meet its target of 45 percent. There is no available data for 2003 or 2004.

This measure is directly related to the priority need of reducing the percentage of births in the State reported to be unintended. This measure is related to the following outcome measures: neonatal, perinatal, postneonatal, infant mortality and reducing the ratio between the Black and White infant mortality rates. All groups of women experience unintended pregnancy. A higher percentage of unintended pregnancies occur in women younger than 20 years of age, not married, Black, Medicaid eligible, and with less than 12 years of education.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Implement Health Metrics recommendations to promote clinic efficiency, reduce wait times, and open access. | | | | X |
| 2. Promote and support integration of services within the clinic. | X | | | |
| 3. Family Planning clinics will be encouraged to offer flexible clinic hours to accommodate the varying needs of clients. | X | | | |
| 4. Family Planning clinicians will complete the Preventive Health course. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Local health departments and contracting physicians provide family planning services. There were 79 sites statewide. Many health departments have integrated service delivery, which facilitates meeting the customer's needs for family planning and STD services. Others have worked to prioritize services for teens and post partum women workers to follow up on missed appointments as well as to do case finding in local communities. The Family Planning waiver (reproductive health care services to all women under 185 percent of poverty) was submitted to CMS for continuation and has been given an extension awaiting a final decision by CMS.

## c. Plan for the Coming Year

The target for 2004 and each year forward has been set at 45 percent. In 2003, SC requested Health Metrics, a private company, to conduct an assessment and provide recommendations concerning access, efficiencies, and effectiveness of the program. A list of recommendations was provided that included open access scheduling, focused client education, patient flow, and staffing models.

Implementing Health Metrics recommendations to promote clinic efficiency, reduce wait times,

and promote access to quality services in all SC counties; promoting and supporting integration of services within the clinic, focusing education and counseling on client needs, ensuring that all Family Planning clinicians complete the Preventive Health Course, and to encourage the offering of flexible clinic hours to accomodate the varying needs of clients has begun in all health regions as part of a set of priorities initiated by the Division of Women and Children's Services. Staff has visited each health region to assist in this implementation. As a result of this implementation, regions have begun to see a significant increases in the show rates of clients keeping their appointments.

State Performance Measure 3: *The number of school districts that are designated as Title V Providers. (Revised 2004)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 70 | 76 | 80 |
| Annual Indicator | | | 65.9 | 77.6 | 64.7 |
| Numerator | | | 56 | 66 | 55 |
| Denominator | | | 85 | 85 | 85 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 65 | 65 | 70 | 75 | 75 |

**Notes - 2002**

Data is not available for 2002.

a. Last Year's Accomplishments

This measure is a Population Based Health Care Service, and is classified as a Capacity measure. This measure is directly related to the priority need of improving the quality and availability of health and health education services in school settings. As of May 2005, only 64.7 percent or 55 of 85 school districts have executed contracts and been trained. This percentage has decreased over the past year because the Mediciad Agency has requested an interpretation from the National Centers for Medicaid and Medicare related to these services and has cautioned school districts that they may be liable for any over reimbursements. Therefore, many school districts are unwilling to undertake this financial risk.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | | | | |

| | DHC | ES | PBS | IB |
|---|---|---|---|---|
| 1. Continue to provide orientation to all new schoold nurses with health deparment staff. | | | | X |
| 2. Provide updated trainings to all Title V designated school districts in order to link schools and children. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The state level nursing consultants and local health regions continue to work closely with their local school districts to coordinate and provide health education, care coordination, immunizations, oral health, primary care, FSS and linkages with other governmental and non-governmental social service providers. Linkages with the Healthy Schools Office of the Department of Education are being strengthened as well.

c. Plan for the Coming Year

The target for next year is to retain the 55 school districts as designated Title V Providers. Linkages between schools, school nurses, school children and their parents, and primary care and enabling service providers are essential components of successful primary care programs for children. School districts in South Carolina are autonomous, so by necessity this effort will be incremental and slow, but the state is committed to strengthening these linkages in the service system.

State Performance Measure 4: *The state has a childhood injury prevention program in place*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |
| Annual Indicator | 53.8 | 53.8 | 69.2 | 91.7 | 87.5 |
| Numerator | 7 | 7 | 9 | 11 | 7 |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | 13 | 13 | 13 | 12 | 8 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2002**

The data for 2002 is not available.

## a. Last Year's Accomplishments

This measure is a Population Based Health Care measure, and is classified as a Capacity measure. Although injuries are the number one killer of children in South Carolina, regions and counties are being encouraged to look at other populations including infants and pregnant women. This measure is directly related to the priority need of reducing preventable injuries in the state. The measure is related to the reducing childhood mortality outcome measure. Seven of the eight regions (87.5%) reported having an injury prevention program in place.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Provide coordination of health education services related to fire protection in the home through current staff. | | **X** | | |
| 2. Provide coordination for distribution of smoke alarms throughout Health Regions I and II. | **X** | | | |
| 3. Train agency staff and the general public about correct usage and installation of child car seats. | **X** | | | |
| 4. Continue to participate in national seat belt safety and child car safety seat events | | **X** | | |
| 5. Conduct Hispanic/Latino safety seat events | **X** | | | |
| 6. Continue to develop the South Carolina Violent Death Reporting System. | | | | **X** |
| 7. Continue to support and participate in the South Carolina Child Fatality Review Committee. | | | | **X** |
| 8. Participate in the development of the State Intentional Injury Strategic Plan. | | | | **X** |
| 9. Support the continued development and implementation of the State Unintentional Injury Strategic Plan. | | | | **X** |
| 10. | | | | |

## b. Current Activities

Injury prevention continues to be an agency priority given the magnitude of the problem (as it is the leading cause of death of children). Injury prevention is fully incorporated into the Health Services Operational Plan through the activities of the Division of Injury and Violence Prevention (DIVP). The DIVP is currently participating in the development and implementation of the state Unintentional Injury Plan and the state Intentional Injury Plan.

Educational brochures were provided to the public regarding poisoning, drowning, fire safety and prevention of injuries due to car crashes. Fire safety educational materials were also provided to clients through the Postpartum Newborn Home Visit Program as part of a partnership with the South Carolina Residential Fire Injury Prevention Program. Local fire departments are installing smoke detectors in homes referred by the home visit program in targeted communities as part of the South Carolina Residential Fire Injury Prevention Program.

Public awareness highlighting the injury problem is conducted through media outlets and participation in community events, such as health fairs. DHEC will also take advantage of events to address the major causes of childhood injury. South Carolina plans to use information gained from Child Fatality Review Committees and the Traumatic Brain Injury Surveillance System and the South Carolina Violent Death Review System statewide to determine possible suggestions and strategies for prevention interventions.

### c. Plan for the Coming Year

The target for next year is for all districts (8/8 or 100 percent) to report that their injury prevention program is in place.

## State Performance Measure 6: *Percent of adolescents who smoke*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 34 | 32 | 27 | 27 | 27 |
| Annual Indicator | 36.0 | 27.6 | 0.0 | 25.8 | NaN |
| Numerator | 1555 | 858 | 0 | 894 | 0 |
| Denominator | 4319 | 3106 | 1 | 3466 | 0 |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 27 | 27 | 27 | 27 | 27 |

**Notes - 2002**

The data for 2002 is not available.

**Notes - 2003**

The 2003 YRBS did not acheve generalized results and thus describes only the sample population. Comparison with the results from previous years should be applied with caution.

**Notes - 2004**

No available data for 2004

## a. Last Year's Accomplishments

This measure is a Population Based Health Care Service, and is classified as a Risk Factor measure. Smoking trends in the teen population have increased steadily over the past decade, and smoking is associated with other risky behaviors. Nearly every adult who smokes (almost 90 percent) took his or her first puff at or before the age of 18. Source: Campaign for Tobacco Free Kids. There was no Tobacco Settlement allocation made for Youth Smoking Prevention programs by the General Assembly for FY '04, nor was there an allocation made for FY '05. Youth Risk Behavior Survey data collected in 2001 indicated that the percentage of youth who reported smoking in the past 30 days was 27.6%. Unfortunately, the YRBS data for 2001 could not be weighted due to sample size insufficiency. Therefore, trends cannot be determined. South Carolina has just completed both the Youth Risk Behavior Survey (YRBS) and Youth Tobacco Survey (YTS) and will have weighted data reports in September 2005. This marks the first year that a successful Youth Tobacco Survey has ever been conducted in the state, and should provide extensive information regarding the attitudes, knowledge, and behavior of the state's youth regarding tobacco use.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Reduce the number of youth and adults in SC who smoke by promoting utilization of the Clinical Practice Guideline: Treating Tobacco Use and Dependence in physician and dental offices throughout the state for standardized counseling and referral | X | | | |
| 2. Increase the number of School Districts in South Carolina who adopt a model tobacco policy which includes smoke-free campuses and events, adoption of science-based tobacco prevention curricula, and counseling and referral for faculty, staff, and stud | | | | X |
| 3. Decrease the number of environments in which non-smokers are exposed to secondhand smoke by promoting the voluntary adoption of smoke-free policies for public places, including Stage Agencies, restaurants, healthcare facilities, eldercare facilities. | | | | X |
| 4. Increase the number of minority owned businesses and Historically Black Colleges and Universities who adopt policies to limit tobacco use and promote tobacco-free lifestyles. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

DHEC, through the Division of Tobacco Prevention and Control conducts outcome-based activities statewide directed at the following four program strategies: prevent youth from initiating tobacco use; promote quitting among youth and adults; eliminate exposure to environmental tobacco smoke; and identify and eliminate health disparities related to

tobacco use. The division's public health media efforts include the Rage Against the Haze campaign, a peer-led social marketing effort targeting adolescents. While the budget for this effort was at all-time low, key components of this effort were maintained, and include an interactive web-based recruitment and messaging center, utilization of a peer-led specialized training curricula, and localized youth-lead programming for policy-based outcomes. At the state level, SCTCP partners with the SC Tobacco Collaborative, the Tobacco Intervention and Prevention Strategy (TIPS),the SC Department of Education, the three major voluntary health organizations: American Cancer Society, American Heart Association, American Lung Association, Hold Out the Lifeline: A Mission to Families, and the SC African-American Tobacco Control Network. At the local level, DHEC district health departments and 12 local tobacco coalitions in four Regions promote these strategies. At both the state and local level, activities focus on policy change, education, surveillance and evaluation.

### c. Plan for the Coming Year

In the coming year, the program will continue to address the four goal areas mentioned above through similar strategies, including community intervention and mobilization, counter marketing, policy and environmental change, surveillance and evaluation. Success in these areas will be monitored and measured through the SC Online Reporting and Evaluation System (SCORES).

State Performance Measure 7: *To implement in at least three health districts the comprehensive risk assessment form for prenatals presenting to the health department for services. (Revised 2004)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 30.1 | 75 |
| Annual Indicator | | | 7.7 | 33.3 | 100.0 |
| Numerator | | | 1 | 4 | 11 |
| Denominator | | | 13 | 12 | 11 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2004**

During 2004, the number of health districts was reduced to 11 from 12. In 2005, the districts will be reorganized again into 8 regions.

### a. Last Year's Accomplishments

This measure has been revised to reflect the priorities for pregnant women, infants and children

that the Bureau, Divisions, and Health Districts have begun to identify and implement. The new measure is: To implement in at least three health districts the comprehensive risk assessment form for prenatal clients presenting to the health department for services.

This measure is an Enabling Service and is classified as a Risk Factor measure. Over the last several years, there has been a substantial shift in the provider makeup of prenatal care in the state. DHEC used to provide prenatal care services statewide, but now only provides these services in 1 of 46 counties, with the private medical community now providing the great majority of prenatal care. DHEC has a role and responsibility; however, to provide enabling services in partnership with the medical community, and to assure that risk appropriate care is being provided, regardless of payment source. This measure is related to the priority need of increasing access to quality risk appropriate care for women and infants in the state. The measure is associated with the infant, neonatal, perinatal, post neonatal mortality outcome measures, and to the rate ratio in the IMR outcome measure as well.

In 2004, all districts or 100 percent have implemented some level of risk assessments for prenatals. This exceeded the goal of 30.1 percent.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Assure that all pregnant women who presnet to the health department are risk assessed through the use of a prenatal risk assessment form. | X | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Staff from several programs in the Bureau have developed priorities and a plan that has the support of upper management. State level staff have provided consultation and encouragement to districts to implement risk assessment of prenatals. Districts have been requested to assure that all pregnant women who present to the health department are risk assessed through use of the Prenatal Risk Screening Form, and linked to an OB provider. Part of this initiative will require that appointments be confirmed.

## c. Plan for the Coming Year

Planned activities for the next year are to provide consultation and encouragement to the regions to continue implemention of prenatal risk assessments for all pregnant wormen. This will be a significant challenge given the anticipated changes in FSS services, other Medicaid covered services, and the anticipated decreased revenues that will result form these changes.

State Performance Measure 9: *Maintain continuation rates for DHEC Family Planning clients to at least 85 percent. (Revised 2004)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 50 | 50 | 85 | 85 | 88 |
| Annual Indicator | 37.0 | 50.0 | 87.7 | 86.3 | 86.7 |
| Numerator | 17 | 23 | 72163 | 71346 | 66781 |
| Denominator | 46 | 46 | 82306 | 82702 | 77051 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 88 | 90 | 90 | 90 | 90 |

**Notes - 2003**

Programmatic data.

a. Last Year's Accomplishments

This measure has been revised. This revised measure is a Direct Health Care Service and is classified as a Risk Factor measure. Family Planning clients who continue their chosen method of birth control is associated with pregnancies that are desired, better birth outcomes and less health risks for women. This measure is related to the following outcome measures: neonatal, perinatal, postneonatal, infant mortality and reducing the ratio between the Black and White infant mortality rates. In 2004, there was a slight percentage increase from 86.3 to 86.7 of women served in DHEC's Family Planning clinics who continued their chosen method of birth control.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Implement Health Metrics recommendations to promote clinic efficiency, reduce wait times, and promote open access. | | | | **X** |
| 2. Promote and support integration of services within the clinic. | **X** | | | |
| 3. Family Planning clinics will be encouraged to offer flexible clinic hours to accommodate the varying needs of clients. | **X** | | | |
| 4. Family Planning clinicians will complete the Preventive Health course. | | | | **X** |
| 5. | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Local health departments and contracting physicians provide family planning services. There were 85 sites statewide. Last year 26 of those sites had extended hours or weekend hours to provide services for those who could not be seen during the routine hours of 8:30 to 5:00 PM. Many health departments have integrated service delivery, which facilitates meeting the customer's needs for family planning and STD services. Others have worked to prioritize services for teens and post partum women workers to follow up on missed appointments as well as to do case finding in local communities. The Family Planning waiver (reproductive health care services to all women under 185 percent of poverty) continues, and has been evaluated. The results documented births averted and substantial cost savings.

Family Planning program staff are currently working with several regions to implement recommendations provided to the state from Health Metrics. Implemented recommendations will increase access to services, offer flexible and timely appointments, open access scheduling, and focused education and counseling.

c. Plan for the Coming Year

The plan for next year is to continue to work with the regional and county health department staff to continue to implement further the Health Metrics recommendations in more clinical sites.

## E. OTHER PROGRAM ACTIVITIES

NON-DUPLICATION OF MEDICAID PAYMENTS TO SSI RECIPIENTS UNDER 16
In SC, services to children under 16 who are receiving Supplemental Security Income are administered by the state Title V program for CSHCN. The program is known as the Supplemental Security Income/Disabled Children's Program (SSI/DCP). Since the enactment of the block grant, the program has been integrated into the community-based services of the CSHCN program. SSI-eligible children not already enrolled are referred to the CRS program for case management services. About 3% of the 100,000+ children served by CRS receive SSI. In addition, SSI recipients are referred to DDSN, School for the Deaf and Blind, Department of Mental Health, and HIV programs. All referrals are through a MOA with each institution.

EPSDT COORDINATION AND STANDARDS:
Assurance is provided so that SC coordinates activities between MCH and the EPSDT Program under Title XIX. DHEC is an EPSDT provider of services to eligible clients. The Division of Women and Children's Services (WCS), in coordination with the health regions, provide a small percentage of all EPSDT screenings in the state. Other providers include private physicians, federally qualified health centers and hospital outpatient clinics. In situations where Public Health clinics do not provide the screenings, they are available through private/public partnerships that provide the traditional public health supportive services to complement medical care. Public health nurses provide education and assist families in securing a medical home for the children. Once the children are in a medical home, public health staff, at the local level, continue to support the providers and clients to assure

adherence to the medical plan outlined by the primary EPSDT provider.

The EPSDT Program in SC follows the periodicity schedule recommended by the American Academy of Pediatrics. WCS was actively involved in the selection of this schedule and was instrumental in providing input into the content of EPSDT screenings. Family Support Services are available as needed by EPSDT clients.

MEDICAID APPLICANT IDENTIFICATION ASSISTANCE
Assurance is provided that DHEC does coordinate with the Title XIX Agency -SC DHHSS in providing funding, assisting in the eligibility process and the provision of services to Pregnant Women, Infants and Children in the State. SC offers Medicaid to Pregnant Women and Infants up to 185% of poverty and Children ages 1 through age 18 up to 150% of poverty (with the latest SCHIP expansion). SC began Medicaid expansion in October 1987. DHEC uses a number of different approaches to identify and assist Medicaid eligible pregnant women and infants. As indicated below, our methods include coordination with other agencies as well as the private sector.

Through the Medicaid ‘Mega' Services contract, paraprofessionals are utilized along with professional staff to recruit potentially eligible individuals into the Medicaid program. Out stationed workers continue to assist with the eligibility process for reproductive aged women.

WIC income guidelines are revised at the same time as Medicaid income guidelines to ensure a coordinated process in identifying those who are Medicaid eligible. When WIC clients are identified as being eligible, appointments are made with the out-stationed Medicaid eligibility workers in the County Health Department, or the County Department of Social Services Office, whichever is applicable. State agencies and the private sector continue to work cooperatively toward the goal of eliminating barriers to Medicaid eligibility which spans the continuum from client identification, assistance with eligibility documentation requirements, eligibility processing at the clinic site, meeting transportation needs, etc., through the process of providing appropriate care or case management.

During 2004, swipe card technology was made available to expedite eligibility determination. Clinics now have the additional option of purchasing a swipe card reader that staff can use to determine eligibility. However, this technology has come with additional expenses, such as the need for several machines, each with a secure Internet phone line, and a per utilization charge of $0.25. The original option of using a 1-800 toll free number is still available. This option has also become costly because it now takes staff approximately 20 minutes to ascertain eligibility status for a client.

F. Technical Assistance

South Carolina has identified technical assistance needs in the areas of performance management, quality assurance, and epidemiology capacity.

## F. TECHNICAL ASSISTANCE

South Carolina has identified technical assistance needs in the are of performance managment.

## V. BUDGET NARRATIVE

### A. EXPENDITURES

Methodology The DHEC Bureau of Maternal and Child Health based the 1989 Maintenance of Effort on the state expenditure of $8,425,466.

FY 1994 was the first year the direct state appropriation for MCH services to the Bureau dropped below the 1989 effort level. The expenditures for FY 1994 were $8,114,682. Therefore, we requested that the 1989 baseline be amended to include expenditures for family planning services. The FY 1989 Family Planning expenditures were $3,020,500.

Identification of Maintenance Effort The State of South Carolina documents a total of $11,445,966 as the 1989 baseline against which future effort is measured. This combines the 1989 state expenditures for maternal and child health services with the Family Planning expenditures.

For FY 2006, state appropriations for the Bureau of Maternal and Child Health Divisions of Women and Children's Services, and Children with Special Health Care Needs are expected to be $10,677,535.

Therefore, the total maintenance of effort for FY 2006 is $11,729,452 calculated by combining the state appropriated dollars for Maternity, Child Health and Children with Special Health Care Needs programs of $10,677,535 with the state appropriated dollars for Family Planning of $1,051,917. The State of South Carolina exceeds the 1989 maintenance of effort requirement by $283,486.

Match Title V matching requirements for the FY 2006 grant award of $11,900,111 is $8,925,083. We identify $8,925,082 of the state allocation of $10,677,535 in the Divisions of Women and Children's Services and Children with Special Health Care Needs as match.

Fiscal Management Procedures Division of Finance's fiscal management procedures was provided in the FY 1995 MCH Title V Grant Application. Another copy can be provided upon request.

Fair Method of Allocating Grant Funds See the attached file for a description of the method used by South Carolina for allocating its MCH and CRS funds to the public health districts.

### B. BUDGET

B. BUDGET
"30-30 Minimum" As required by OBRA '89, South Carolina allocates a minimum of 30% of Federal Block Grant Funds for preventive and primary care services to children, and a minimum of 30% is allocated to children with special health care needs that are part of a system of services which promotes family-centered, community based coordinated care.

## VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

## X. APPENDICES AND STATE SUPPORTING DOCUMENTS

### A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

### B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

### C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

### D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.